LOGAN EYE INSTITUTE

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# POST- PROCEDURE REPORT

**Patient:** _____ **Date:** _____

Procedure: OD ☐LASIK ☐PRK ☐SMILE ☐Kamra ☐RLE Date: _____ Referring Doctor_____

OS ☐LASIK ☐PRK ☐SMILE ☐Kamra ☐RLE Date: _____

Post Op Day: OD_____ OS _____ OU _____

CC:_____

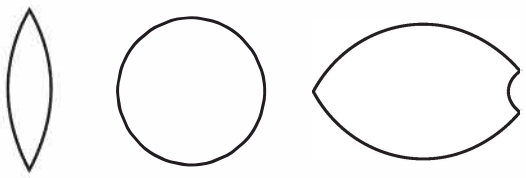
_____

Meds: OD_____OS_____

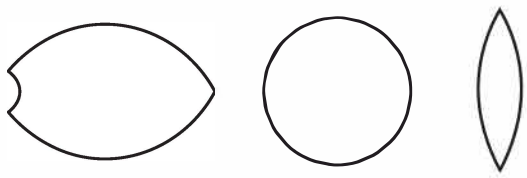
| | SPH | CYL | AXIS | ADD | Vcc | Vcc OU | Vsc | Vsc OU | Vsc Near | Vcc Near | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DRY | | | | | 20/ | 20/ | 20/ | 20/ | J | J | T | OD: | OS: |
| | | | | | 20/ | | 20/ | | J | J | | Time: | |
| CYCLO | | | | 20/ | TOPO | OD ☐Reg ☐Asym ☐Irr ☐Other: _____ | | | | | | | |
| | | | | 20/ | | OS ☐Reg ☐Asym ☐Irr ☐Other: _____ | | | | | | | |

**Slit Lamp Examination:**( Please draw flaps for LASIK)

☐ **OD** – Except as noted, corneal epithelium, interface, and associated tissue signs are normal or as expected



☐ **OS** – Except as noted, corneal epithelium, interface, and associated tissue signs are normal or as expected



A ☐ Normal post-operative result, except as noted:

_____

_____

P ☐ Continue post-operative treatment

_____

_____

Reviewed Post-Procedure Instruction: Yes☐ No☐

Reviewed Meds: Yes☐ No☐

RTC: _____

Dr. _____
***(signed)***

EMAIL FORM

CLEAR FORM