MONSON VISION

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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:_____

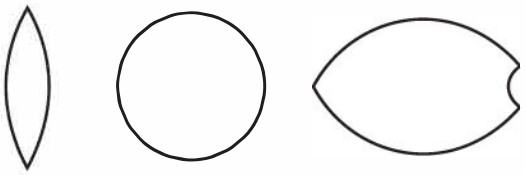
_____

Meds: OD_____OS_____

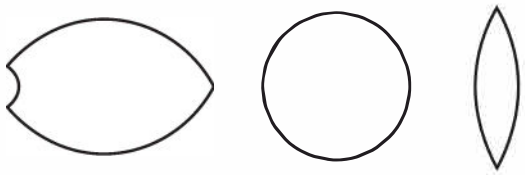
	SPH	CYL	AXIS	ADD	Vcc	Vcc OU	Vsc	Vsc OU	Vsc Near	Vcc Near			
DRY					20/	20/	20/	20/	J	J	T	OD:	OS:
					20/		20/		J	J		Time:	
CYCLO				20/	TOPO	OD ☐Reg ☐Asym ☐Irr ☐Other: _____							
				20/		OS ☐Reg ☐Asym ☐Irr ☐Other: _____							

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 to: emily@monsonvision.com

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EMAIL FORM CLEAR FORM