**POST-OPERATIVE REPORT**

Patient Name: Sex: DOB: Age: Co-Managing Doctor: DOS: Exam Date:

**VISIT (circle one):** 1 Day 1 Mo 6 Mo 1 Yr Interim VA√ Dry Eye √ **PROCEDURE: LASIK / PRK / SMILE OCULAR MEDICATIONS (circle):** Ciprofloxacin / Pred / FML / Artificial Tears Other:

**PATIENT COMMENTS:**

OD OS

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| --- | --- | --- | --- |
| **REFRACTIVE DATA** | | | |
| **UCDVA: UCNVA:** | **UCDVA OU:** | | **UCDVA: UCNVA:** |
| **sphere cyl axis**  **\*Refraction 20/**  **Add:**  **\*(Required at all visits ≥ 1 month)** | | **sphere cyl axis**  **\*Refraction 20/**  **Add:** | |
| **ADDITIONAL TESTING** | | | |
|  | |  | |
| **OCULAR HEALTH** | | | |
| **Y/ N SPK Y/ N**  **Y/ N Abrasion Y/ N**  **Y/ N Haze Y/ N**  **Y/ N Edema Y/ N Y/ N Interface Debris Y/ N Y/ N Epi Ingrowth Y/ N Y/ N Microstriae Y/ N Y/ N Displaced Flap Y/ N** | | | |

**ASSESMENT / PLAN:**

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**RTC:**

**Doctor’s Signature**

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| **FAX TO 303-793-3008 AFTER EACH VISIT** | | |
| □ **Please Call** | □ **Please Fax Comments** | □ **No Reply Requested** |
| **DLI USE ONLY** | | |
| □ **O.D. Reviewed** | □ **Contacted Co-Care Doctor** |  |

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