VISIONMAX EYE CENTRE

Primary Eye care Provider Refractive Surgery Follow Up

Patient Name (Dr./Mr./Ms./Miss):______________________________

DOB (m/d/y):______________________ Examination Date:______________________

Assessing Doctor:______________________ OD ☐ MD ☐

Surgery Date:	Type:		LASIK		Presbyond		PRK		ICL		SMILE		RLE		Cross Linking

		OD		OS	
Pre-Operative Rx:		______		______	
EXAMINATION					
Visual Acuity Without Correction		______		______	
Manifest Refraction		______		______	
Keratometry		______		______	
Intraocular Pressure		______ mmHg		______ mmHg	
Ocular Medications:	Current	______		______	
LASIK	Interface Clear	☐ Yes	☐ No	☐ Yes	☐ No
	Flap Smooth	☐ Yes	☐ No	☐ Yes	☐ No
	Flap in good condition	☐ Yes	☐ No	☐ Yes	☐ No
PRK/CXL	Haze Grading (Please specify)	☐ Clear ☐ Mild ☐ Marked		☐ Clear ☐ Mild ☐ Marked	
SMILE	Interface Clear	☐ Yes	☐ No	☐ Yes	☐ No
	CAP Edema Present	☐ Yes	☐ No	☐ Yes	☐ No
RLE/ICL	Iridotomy/s patent (ICL hyperopic only)	Yes ☐	No ☐	Yes ☐	No ☐
	IOL.ICL centred	☐ Yes	☐ No	☐ Yes	☐ No
	Crystalline lens grading (ICL only)	☐ Yes	☐ No	☐ Yes	☐ No
	Periphery intact	☐ Yes	☐ No	☐ Yes	☐ No
	Vaulting grading (Visual estimate of space between back surface of ICL and front of crystalline lens, i.e., If space is 2x central corneal thickness, then 2+ vault)	______ Vaulting		______ Vaulting	
	Toric ICL orientation (in degrees)	______ Degrees		______ Degrees	

Comments or questions: ______________________________

Treatment Plan: ______________________________

Is the patient satisfied with the surgical outcome? ☐ Yes ☐ No

Comments:______________________________

Assessing Doctor's Fax:______________________ **W**ould you like a reply: Yes ☐ No ☐

Signature of Assessing Doctor:______________________________

Surgeon Comments: ______________________________