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		PRK		ICL		SMILE		RLE		Cross Linking

		OD		OS	
Pre-Operative Rx:		___		___	
EXAMINATION					
Visual Acuity Without Correction		___		___	
Manifest Refraction		___		___	
Best Corrected Visual Acuity		___		___	
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:___ Would you like a reply: Yes ☐ No ☐

Signature of Assessing Doctor:___

Surgeon Comments: ___

___

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