

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	
				<b>OD</b>					<b>OS</b>
Pre-Operative Rx:		_____			_____			_____	
<b>EXAMINATION</b>									
Binocular Visual Acuity		Distance: _____			Intermediate: _____			Near: _____	
Post-operative Visual Acuity (distance)		_____			_____			_____	
Manifest Refraction		_____			_____			_____	
Best Corrected Visual Acuity (distance)		_____			_____			_____	
Best Corrected Visual Acuity (near, when applicable)		_____			_____			_____	
Keratometry		_____			_____			_____	
Intraocular Pressure		_____ mmHg			_____ mmHg			_____ mmHg	
Ocular Medications:		Current			_____			_____	
<b>LASIK</b>	Interface Clear	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No	
	Flap Smooth	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No	
	Flap in good condition	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No	
<b>PRK/CXL</b>	Haze Grading (Please specify)	<input type="checkbox"/> Clear		<input type="checkbox"/> Clear		<input type="checkbox"/> Clear			
		<input type="checkbox"/> Mild		<input type="checkbox"/> Mild		<input type="checkbox"/> Mild			
		<input type="checkbox"/> Marked		<input type="checkbox"/> Marked		<input type="checkbox"/> Marked			
<b>SMILE</b>	Interface Clear	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No	
	CAP Edema Present	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No	
<b>RLE/ICL</b>	Iridotomy/s patent (ICL hyperopic only)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	IOL ICL centred	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No	
	Crystalline lens grading (ICL only)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No	
	Periphery intact	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No	
	Vaulting grading	_____ Vaulting			_____ Vaulting			_____ Vaulting	
<small>(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)</small>									
Toric ICL orientation (in degrees)		_____ 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: \_\_\_\_\_