VISIONMAX EYE CENTRE

Primary Eye care Provider Refractive Surgery Follow Up

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

DOB (m/d/y):_____ **E**xamination Date:_____

Assessing Doctor:_____Doctor's Clinic Name: _____ ☐ 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:_____ **W**ould you like a reply: Yes ☐ No ☐

Signature of Assessing Doctor:_____

Surgeon Comments: _____

_____