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:_____ OD ☐ MD ☐

Surgery Date:	Type:		LASIK		Presbyond		PRK		ICL		SMILE		CLR*		Cross Linking

		OD		OS	
Pre-Operative Rx:					
EXAMINATION					
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	
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
CLR*/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: _____

_____

*Custom Lens Replacement (CLR), previously called Refractive Lens Exchange (RLE).

Visionmax Eye Centre Edmonton Fax: (780) 452-4114