



EVERGREEN EYE CENTER

Refractive Procedure Post OP Report

Thank you for your referral. Please complete this form and return by mail at your earliest convenience. Items in **BOLD** we would like completed to track our surgical outcomes, other data is optional.

Patient's Name: _____ **D.O.B:** _____ **Date of Exam:** _____

Subjective: _____

Objective: Right Eye Left Eye

Surgery Performed: LASIK ICL Other _____

Date of Surgery: _____

This Post Op Visit: 1 Week 1 Month 6 Month 1 Week 1 Month 6 Month

Uncorrected VA: 20 / ____ 20 / ____

Manifest Refraction: _____ 20 / _____ 20 /

Keratometry: Manual Auto _____

OD

OS

Cornea _____
Cap Position _____
Interface _____
Epithelial Surface _____
Fluorescein _____



Conjunctiva _____

Anterior Chamber _____

Lens _____

IOP Air _____ mm Hg@ _____ Applanation _____ mm Hg@ _____

Assessment: _____ **Plan:** _____

Patient Satisfaction: Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied

Physician Name: _____ Signature: _____

Please Print

Keep the top copy for your records. Fold and mail the back copy to Evergreen Eye Center.