



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

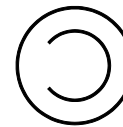
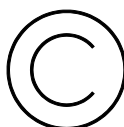
Cornea _____ _____

Cap Position _____ _____

Interface _____ _____

Epithelial Surface _____ _____

Fluorescein _____ _____



Conjunctiva _____ _____

Anterior Chamber _____ _____

Lens _____ _____

IOP Air: _____ mm Hg @ _____ _____ mm Hg@_____

Applanation

Assessment: _____ **Plan:** _____

Patient Satisfaction: Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied

Physician Name: _____ Signature: _____

Please Print