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World Class Eye Care 7 Days A Week

POST-PROCEDURE CARE – LASIK

Patient Name: _____ Co-managing Contact Person: ☐ Doctor: ☐ Assistant:

Co-managing Doctor: _____ Email: _____ Phone: _____ Fax: _____

RIGHT EYE

Procedure Date: Month: _____ Day: _____ Year: _____

Procedure Type: ☐ Primary LASIK: ☐ Enhancement

Original RX: _____

Original BCVA: 20 / Age: Aim: Plano Mono

EXAM

Date: Month: _____ Day: _____ Year: _____

Circle: Day 1 Week 1 2 3 Month 1 2 3 6 9 12

PT Remarks: _____

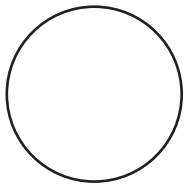
MEDS: _____ (circle) Q 1hr QID TID BID QD NiL

_____ (circle) Q 1hr QID TID BID QD NiL

UCVA: 20 / (blurry / glare / double / fluctuates)

AUTO REFRACTION: _____

REFRACTION:
(Wet / Dry) _____ 20 / _____



LASIK Corneal Flap: (circle)

Position:	excellent	dislodged	striae
Clarity:	clear	edema	haze
Interface:	clear	opacities	Epi. ingrowth
Edges:	smooth	rolled	eroded

IOP (after 1 week/applanation): _____ mmHg

Doctor comments: ☐ excellent ☐ stable ☐ enhancement

Enhancement: ☐ myopia / hyperopia / cylinder / epithelial ingrowth / central island
☐ SightMD to contact patient ☐ Patient will call SightMD

Treatment: _____

Follow-up: ☐ with co-managing Doctor ☐ with SightMD

Next visit in: 1 2 3 4 5 6 weeks / months

LEFT EYE

Procedure Date: Month: _____ Day: _____ Year: _____

Procedure Type: ☐ Primary LASIK: ☐ Enhancement

Original RX: _____

Original BCVA: 20 / Age: Aim: Plano Mono

EXAM

Date: Month: _____ Day: _____ Year: _____

Circle: Day 1 Week 1 2 3 Month 1 2 3 6 9 12

PT Remarks: _____

MEDS: _____ (circle) Q 1hr QID TID BID QD NiL

_____ (circle) Q 1hr QID TID BID QD NiL

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AUTO REFRACTION: _____

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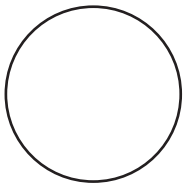

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Treatment: _____

Follow-up: ☐ with co-managing Doctor ☐ with SightMD

Next visit in: 1 2 3 4 5 6 weeks / months

Comments: _____

Doctor Signature _____ Date: _____

SightMD is committed to providing the best care and clinical results. SightMD Nomograms are developed and refined with post-op data. Please fax or mail this completed form to SightMD.