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601 Suffolk Avenue
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1758 Brentwood Road
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World Class Eye Care 7 Days A Week

POST-PROCEDURE CARE – PRK / SURFACE ABLATIONS

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

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

RIGHT EYE

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

Procedure Type: ☐ Primary PRK: ☐ Custom ☐ Conventional ☐ Enhancement

Pre-procedure RX: _____

Original BCVA: 20/ Age: Aim: Plano Mono

EXAM

Date: Month: _____ Day: _____ Year: _____

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

PT Remarks: _____

MEDS: _____ (circle) QID TID BID QD Q2D NiL

_____ (circle) QID TID BID QD Q2D NiL

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

AUTO REFRACTION: _____

REFRACTION:
(Wet / Dry) _____ 20 /

IOP: _____
(app. tonometry)

CORNEAL CLARITY

HAZE GRADE
☐ Clear
☐ Trace Reticular
☐ Mild Reticular
☐ Moderate Confluent
☐ Severe Confluent

HAZE PATTERN
☐ Diffuse
☐ Focal
☐ Arcuate

Doctor comments: ☐ excellent ☐ stable ☐ enhancement

Enhancement: ☐ myopia / hyperopia / cylinder / 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 days / weeks / months

LEFT EYE

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

Procedure Type: ☐ Primary PRK: ☐ Custom ☐ Conventional ☐ Enhancement

Pre-procedure RX: _____

Original BCVA: 20/ Age: Aim: Plano Mono

EXAM

Date: Month: _____ Day: _____ Year: _____

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

PT Remarks: _____

MEDS: _____ (circle) QID TID BID QD Q2D NiL

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Treatment: _____

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

Next visit in: 1 2 3 4 5 6 days / 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.