PRK/SURFACE ABLATION POST-PROCEDURAL CARE FORM

SightMD® eye doctors • eye surgeons

Fax this form to **631.393.8538**

Patient Name: _____

Co-Managing Contact Person:_____ ☐ Doctor ☐ Assistant

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

RIGHT EYE

Procedure Date: _____ _____

Procedure Type: ☐ Primary PRK ☐ Enhancement

Pre-Procedure RX: _____

Original BCVA: 20/____ Age: _____ Aim: _____ Plano: ____ Mono: ____

EXAM

Date: _____ Circle One: Day 1 Week 1 2 3 Month 1 2 3 6 9 12

PT Remarks: _____

MEDS: _____ Circle: QID TID BID Q2D NiL

_____ Circle: QID TID BID Q2D NiL

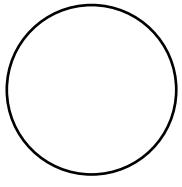
UCVA: 20/____ (blurry / glare / double / fluctuates)

AUTO REFRACTION: _____

REFRACTION: (wet / dry) _____ 20/_____

CORNEAL CLARITY

IOP: _____
(app. tonometry)



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 / epithelial ingrowth / central island

☐ SightMD to contact patient ☐ Patent 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: _____ _____

Procedure Type: ☐ Primary PRK ☐ Enhancement

Pre-Procedure RX: _____

Original BCVA: 20/____ Age: _____ Aim: _____ Plano: ____ Mono: ____

EXAM

Date: _____ Circle One: Day 1 Week 1 2 3 Month 1 2 3 6 9 12

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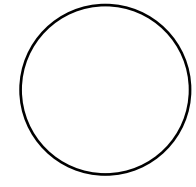

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Next visit in: 1 2 3 4 5 6 weeks / months

Comments: _____

Doctor Signature: _____ Date: _____