

EYE CENTER OF TEXAS

Fax to 713-357-7278

Post-Procedure Report

Patient: _____ **Date:** _____

Procedure: OD LASIK PRK PTK Date: _____ Refractive Goal: OD _____ Examining Doctor _____
 OS LASIK PRK PTK Date: _____ OS _____

CC: _____

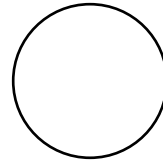
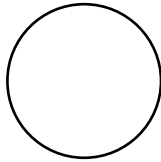
Meds: OD _____ OS _____

	SPH	CYL	AXIS	ADD	Vcc	Vcc OU	Vsc	Vsc OU	Vsc Near	Vcc Near		
B V A					20/	20/	20/	20/	J	J	T	
					20/		20/		J	J		Time
C Y C L O				20/	K	OD _____ Mires Clear +1D +2D +3D						
				20/		OS _____ Mires Clear +1D +2D +3D						

Slit Lamp Examination: (Please draw flaps for LASIK)

OD – Except as noted, corneal epithelium, interfaces, and associated tissue signs are normal or as expected

OS – Except as noted, corneal epithelium, interfaces, and associated tissue signs are normal or as expected



TOPO: No Yes

A Normal post-operative result Interface wrinkle affecting vision

P Continue post-operative treatment Smooth cap

Reviewed Post-Procedure Instruction: Yes No

Reviewed Meds: Yes No

RTC: _____ Optometrist _____

Physician: _____ Assistant _____

Please send to EYE CENTER OF TEXAS AT 6565 West Loop South, Suite 650, Bellaire, Texas 77401

Faxed #713-357-7278 Mailed on (date) _____ by (init.) _____