POST-PROCEDURE REPORT

FAX TO 713-357-7278

PATIENT _____ **DATE** _____

PROCEDURE OD LASIK PRK PTK Date _____ Refractive OD _____ Examining Doctor _____

OD LASIK PRK PTK Date _____ Goal OS _____

CC _____

_____

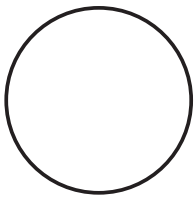
MEDS OD _____ OS _____

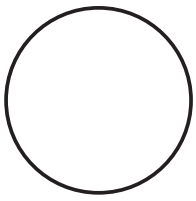
	SPH	CYL	AXIS	ADD	Vcc	Vcc OU	Vsc	Vsc OU	Vsc Near	Vcc Near		
BVA					20/	20/	20/	20/	J	J	T	
					20/		20/		J	J		Time
CYCLO				20/	K	OD _____ Mires Clear +1D +2D +3D						
				20/		OS _____ Mires Clear +1D +2D +3D						

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 *(intials)* _____

EYE CENTER OF TEXAS
Leaders in Eye Care

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