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: ____

____

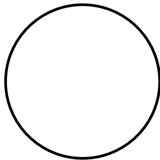
Meds: OD ______________________________ OS ______________________________

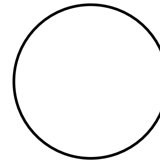
	SPH	CYL	AXIS	ADD	Vcc	Vcc OU	Vsc	Vsc OU	Vsc Near	Vcc Near		
BVA					20/	20/	20/	20/	J	J	T	
					20/		20/		J	J		Time
CYCLO				20/	K	OD______________			Mires Clear +1D +2D +3D			
				20/		OS ______________			Mires Clear +1D +2D +3D			

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 *(init.)* ________**

Revised:04/15/2009