EYE Q Premium Laser

Co-Management Post-Operative Assessment Form Date: ________________

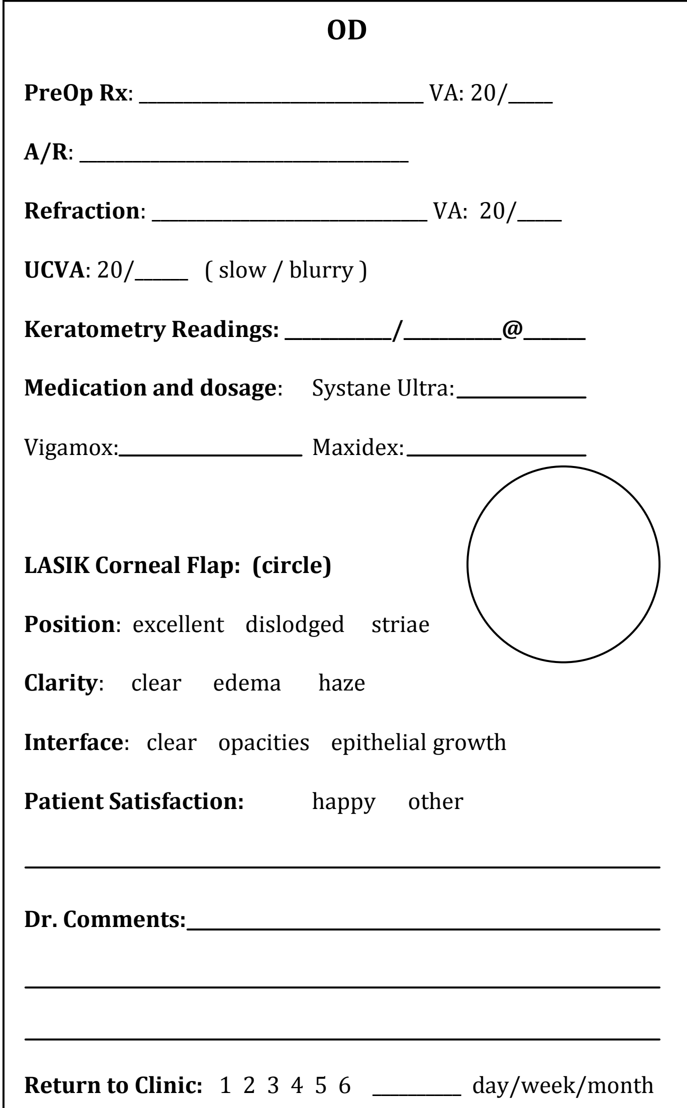
Co-Managing Doctor: ____ **Office Phone #:**____________________

Practice Name: ____

Patient Name:_________________________________ **DOB:**_________ **Patient's Phone #:**____________________

Procedure: _____________________________ Procedure Date: __________________ Surgeon: ___________________

Post Op Visit (please circle): 1 week 1 month 3 month 6 month other



OD

PreOp Rx: ___________________________ VA: 20/____

A/R: _______________________________

Refraction: __________________________ VA: 20/____

UCVA: 20/_____ (slow / blurry)

Keratometry Readings: __________/_________@______

Medication and dosage: Systane Ultra:____________

Vigamox:_________________ Maxidex:_________________

LASIK Corneal Flap: (circle)

Position: excellent dislodged striae

Clarity: clear edema haze

Interface: clear opacities epithelial growth

Patient Satisfaction: happy other

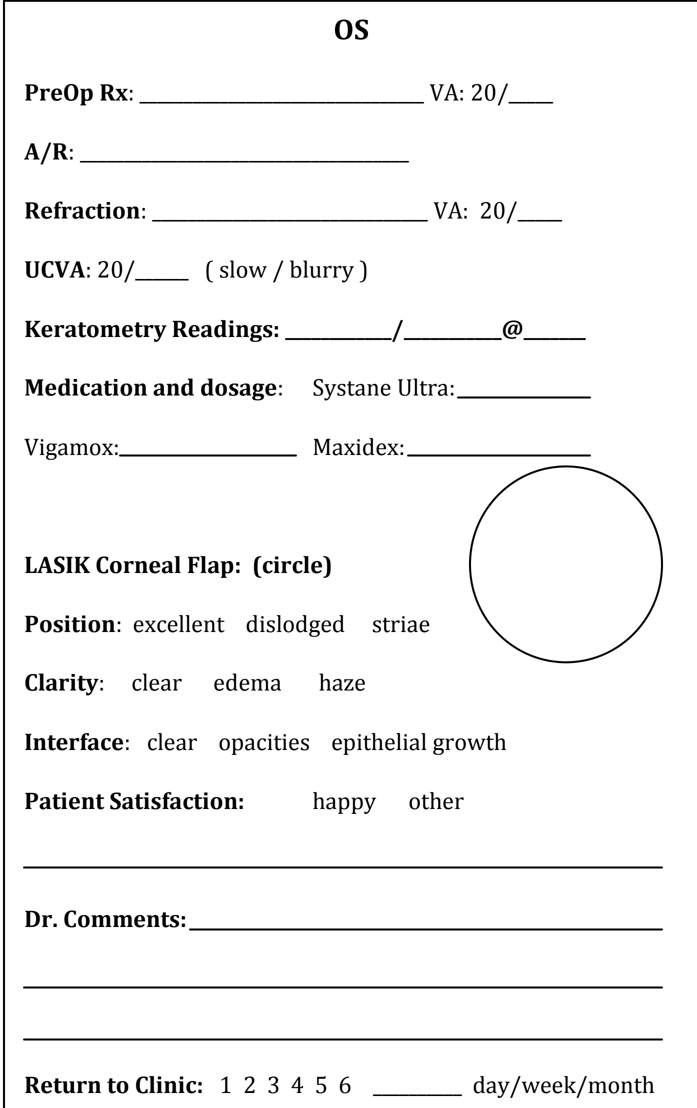
____

Dr. Comments:____

____

____

Return to Clinic: 1 2 3 4 5 6 _______ day/week/month



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Questions to Surgeon:

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