LASER VISION
LONDON

PRK POST-OPERATIVE FORM

P 519-204-7777 | **F** 519-204-1010

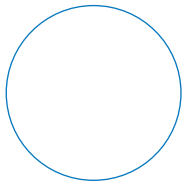
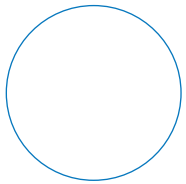
Name _____ D.O.B. _____ Tx: ☐ PRK ☐ OD ☐ OS ☐ OU

Co-Managing Dr. _____ Dr. Phone_____ Dr. Fax _____ Dr. Email _____

Surgery Date_____ Post-operative Visit ☐ Day _____ ☐ Week _____ ☐ Month _____

Med: / Dosage: ☐ Vigamox _____ ☐ Prolensa _____ ☐ Lotemax _____ ☐ Artificial Tears: ☐ PF ☐ Regular _____

OD Target: ☐ Plano ☐ Other _____ **OS Target:** ☐ Plano ☐ Other _____

UCDVA	20 / ☐ blurry ☐ glare ☐ dbl ☐ fluctuates			20 / ☐ blurry ☐ glare ☐ dbl ☐ fluctuates		
Refraction	_____ 20 /			_____ 20 /		
SLIT LAMP	**CORNEAL CLARITY**	**HAZE GRADE**	**HAZE PATTERN**	**CORNEAL CLARITY**	**HAZE GRADE**	**HAZE PATTERN**
		☐ Clear ☐ Trace Reticular ☐ Mild Reticular ☐ Moderate Confluent ☐ Severe Confluent	☐ Diffuse ☐ Focal ☐ Arcuate		☐ Clear ☐ Trace Reticular ☐ Mild Reticular ☐ Moderate Confluent ☐ Severe Confluent	☐ Diffuse ☐ Focal ☐ Arcuate
IOP	_____ mmHg			_____ mmHg		

Next followup visit scheduled: _____ ☐ day ☐ week ☐ month ☐ year Follow up required with LVL? ☐ **Y** ☐ **N**

Doctor's Comments/Treatment: ☐ excellent ☐ stable ☐ enhancement

_____

_____

Dr. Signature _____ Date _____