POST-OPERATIVE EXAM FORM
EXCIMER LASER

Patient ____________________ D.O.B.(m/d/y) _____/_____/_____ Date _____/_____/_____

Surgery Date OD _____/_____/_____ Surgery Date OS _____/_____/_____

F/U OD 24h, 48h, 72h, 1wk, 1mo, 3mo, 6mo, 1y, ________ m / y **F/U OS** 24h, 48h, 72h, 1wk, 1mo, 3mo, 6mo, 1y, ________ m / y

WGA / PRK / SBK / RLE / RETX / Other: ____________ **WGA / PRK / SBK / RLE / RETX / Other:** ____________

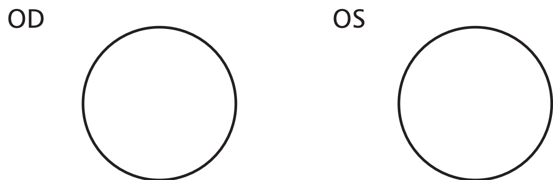
CC: ____________________

Current gtts OD ____________________

OS ____________________

	UCVA	REFRACTION	BCVA	K READINGS	IOP
OD	20/____	______ +______ x ______	20/ ____	**OD** ____________	OD ____________
OS	20/____	______ +______ x ______	20/ ____	**OS** ____________	**OS** ____________
N/V	20/____		**MIRES** ☐ Clear ☐ Irregular		

SLIT LAMP EXAM



	OD		OS	
Interface Debris	☐ yes	☐ no	☐ yes	☐ no
DLK	☐ yes	☐ no	☐ yes	☐ no
Striae	☐ yes	☐ no	☐ yes	☐ no
Edema	☐ yes	☐ no	☐ yes	☐ no
Haze	☐ yes	☐ no	☐ yes	☐ no

Tx PLAN/COMMENTS :

____

____

____

Next Follow-up Appointment: ____________________

PAYMENT (Office use only)

FEC ____________

PT ____________

N/A ____________

On a scale of 1-10, how happy are you with your results?

____

Co-Managing Doctor's Name:

____

Phone Number (if necessary for Follow-up call):

____

Follow-up Notes to OD's (from Focus)

PLEASE EMAIL the completed form to **info@focuseye.com**
or **FAX** to **613-724-6264** (Ottawa) or **613-544-2632** (Kingston)

1565 Carling Ave., Suite 110, **Ottawa**, ON K1Z 8R1 ▪ 1-800-IN-FOCUS (1-800-463-6287) ▪ 613-724-3937 ▪ fax 613-724-6264 ▪ **www.focuseye.com**
Hotel Dieu Hospital, 166 Brock St., Suite 325, **Kingston**, ON K7L 5G2 ▪ 1-877-460-6029 ▪ 613-542-5000 ▪ fax 613-544-2632 ▪ **www.focuseye.com**

F4 Rev. 3 NOV 2015