BARRIE
LASIK CENTRE

Post-operative Evaluation

Exam Date_____

Month: 1 3 6 12 Other: _____

Doctor Name: _____

O ce Contact: _____

O ce Phone: _____

Original Procedure Date: _____

Enh. Procedure Date: _____

Comanagement Fees Received: Yes ❑ No ❑

Patient Name: _____

Phone (H): _____

Phone Day: _____

Birthdate:_____ Age: _____

Gender: Male ❑ Female ❑

LASIK ❑ PRK ❑ CXL ❑

Pre-Procedure RX

	SPHERE	CYL.	AXIS	BCVA
OD				20/

	SPHERE	CYL.	AXIS	BCVA
OS				20/

UCVA OD 20/ OS 20/

Patient Comments:_____

_____

Subjective Refraction

	SPHERE	CYL.	AXIS	
OD				20/

	SPHERE	CYL.	AXIS	
OS				20/

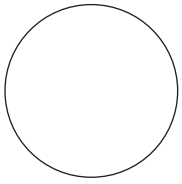
Cycloplegic Refraction (At the 3 month post-operative exam if vision is not satisfactory or if enhancement is considered.)

	SPHERE	CYL.	AXIS	
OD				20/

	SPHERE	CYL.	AXIS	
OS				20/

Slit Lamp Exam

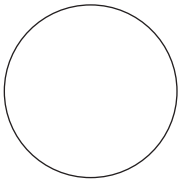
OD



_____ I.O.P._____

Clear
Haze
Debris
Ingrowth

Clear
Haze
Debris
Ingrowth



OS

Meds

❑ Tobradex ❑ Artificial Tears ❑ Other _____

Doctor Comments:_____

_____

Requesting Enhancement: ❑ Yes ❑ No _____

For Office Use:

Recommended Procedure: _____

Notified Patient: _____

Notified OD: _____

204 - 500 Huronia Road, Barrie, ON L4N 8X3 | Ph. 705-797-1700 Fax 705-797-1800 | www.barrielasik.com