

# Laser Vision Correction Quality Assurance 1 Day Post-op Report



To help us maintain the highest quality surgical outcomes, we appreciate information from your 1-day post-operative exam. Please complete and mail this form at your earliest convenience.

Thank you for sharing your exam findings.

**Patient's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Date of Exam** \_\_\_\_\_  
**Type of Surgery**      LASIK      Surface laser vision correction

**SUBJECTIVE**

\_\_\_\_\_  
 \_\_\_\_\_

**OBJECTIVE**

**RIGHT EYE**

**LEFT EYE**

Date of Surgery      \_\_\_\_\_

Uncorrected VA      20/\_\_\_\_\_      20/\_\_\_\_\_

Best Corrected VA      20/\_\_\_\_\_ (optional)      20/\_\_\_\_\_ (optional)

Manifest Refraction      \_\_\_\_\_ - \_\_\_\_\_ x \_\_\_\_\_ 20/\_\_\_\_\_      \_\_\_\_\_ - \_\_\_\_\_ x \_\_\_\_\_ 20/\_\_\_\_\_

Conjunctiva      clear      other \_\_\_\_\_      clear      other \_\_\_\_\_

Cornea:

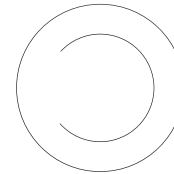
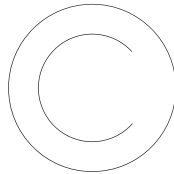
Cap Position      centered      other \_\_\_\_\_      centered      other \_\_\_\_\_

Epithelial Surface      clear      other \_\_\_\_\_      clear      other \_\_\_\_\_

Haze      normal      other \_\_\_\_\_      normal      other \_\_\_\_\_

Interface      clear      other \_\_\_\_\_      clear      other \_\_\_\_\_

Fluorescein      normal      other \_\_\_\_\_      normal      other \_\_\_\_\_



Anterior Chamber      clear      other \_\_\_\_\_      clear      other \_\_\_\_\_

**ASSESSMENT**

**PLAN**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Comments

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please contact us by telephone if you require assistance with any post-operative condition.

Physician Name \_\_\_\_\_ Signature \_\_\_\_\_  
 Please Print