

# Laser Vision Correction Quality Assurance

## 1 Week–6 Month Post-op Report



To help us maintain the highest quality surgical outcomes, we appreciate information from your 1-week, 1-month and 6-month post-operative exams. Items listed in **bold** are data we request for our outcomes database—other data is optional. 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** \_\_\_\_\_

**This Post-op Visit**      1 week      1 month      6 month      1 week      1 month      6 month

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

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

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

**K's**    manual    auto      \_\_\_\_\_ - \_\_\_\_\_ @ \_\_\_\_\_      \_\_\_\_\_ - \_\_\_\_\_ @ \_\_\_\_\_

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

Cornea:

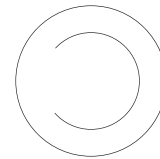
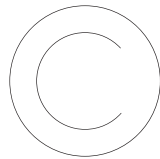
Cap Position      centered      other \_\_\_\_\_      centered      other \_\_\_\_\_

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 \_\_\_\_\_

IOP    air    applanation      \_\_\_\_\_ mm Hg @ \_\_\_\_\_      \_\_\_\_\_ mm Hg @ \_\_\_\_\_

### ASSESSMENT

### PLAN

\_\_\_\_\_

\_\_\_\_\_

How do you rate this patient's satisfaction?      Very Satisfied      Satisfied      Neutral      Dissatisfied      Very Dissatisfied

Comments

\_\_\_\_\_

\_\_\_\_\_

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

Physician Name \_\_\_\_\_ Signature \_\_\_\_\_

Please Print