NJ EYE AND EAR
LASIK CENTER

LASIK/PRK Post-op Form

Fax or e-mail to:
toakes@njeyeandear.com
Fax: (866)-351-9920

☐ LASIK ☐ OU ☐ OD ☐ OS
☐ PRK ☐ OU ☐ OD ☐ OS

Patient: _____ DOB: _____/_____/_____ Age: _____
Affiliate: _____ Phone: _____ Fax: _____

OD

Procedure date: _____/_____/_____ Target: Distance / Mono

Procedure Type: initial / Enhancement
Post-op Date: _____/_____/_____
day _____ week _____ month _____ (from surgery)

Patient Comments: _____
_____
_____

Meds: _____
_____
_____

UCVA: 20/ _____ Manifest (wet / dry) _____ 20/ _____

Refraction (1 mo. & 3 mo.)
_____ **20/ _____**

Biomicroscopy
Adnexia: Normal / Other
Conjuctiva: Normal / Other
Tear Film: Normal / Dry
IOP: _____ @

Flap Evaluation
Position: Excellent / Decentered
Clarity: Clear / Edema / Haze
Edges: Smooth / Rolled

Summary: Excellent / Stable / Refer to Dr. Hu / Other
Treatment / FollowUp / Comments: _____
_____
_____

OS

Procedure date: _____/_____/_____ Target: Distance / Mono

Procedure Type: initial / Enhancement
Post-op Date: _____/_____/_____
day _____ week _____ month _____ (from surgery)

Patient Comments: _____
_____
_____

Meds: _____
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Edges: Smooth / Rolled

Summary: Excellent / Stable / Refer to Dr. Hu / Other
Treatment / FollowUp / Comments: _____
_____
_____

Affiliate Signature: _____ Date: _____/_____/_____