

Patient Name: _____ Age: _____ Tx: LASIK ENHANCEMENT

Co-Managing Doctor: _____ Dr. Phone: _____

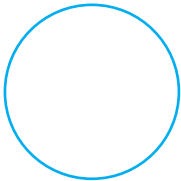
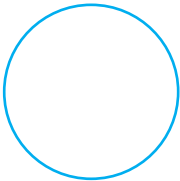
Dr. Fax: _____ Dr. Email: _____

Original Treatment Date: D: _____ M: _____ Y: _____ Postoperative Visit: D: _____ M: _____ Y: _____

Original Rx OD: _____ 20/ _____ OS: _____ 20/ _____

Meds/Dosage: Pred Forte _____ / FML 0.1 _____ / Zymar _____ / Artificial Tears: PF/Regular _____

OD Target: Plano/Other: _____ OS Target: Plano/Other: _____

UCDVA	20/ (blurry/glare/dbl/fluctuates)	20/ (blurry/glare/dbl/fluctuates)
Refraction	20/	20/
SLIP LAMP	LASIK Corneal Flap: (circle) Position: excellent/ dislodged/striae Clarity: clear/edema/haze Interface: clear/opacities/epithelial ingrowth Edges: smooth/rolled/eroded 	LASIK Corneal Flap: (circle) Position: excellent/ dislodged/striae Clarity: clear/edema/haze Interface: clear/opacities/epithelial ingrowth Edges: smooth/rolled/eroded 
	KAMRA: Position: well centred/displaced >0.5mm Haze: None/1+/2+/3+/4+	KAMRA: Position: well centred/displaced >0.5mm Haze: None/1+/2+/3+/4+
IOP	mmHg	mmHg

 Next followup visit scheduled: _____ day/week/month/year Followup required with BLEC: **Y/N**

Doctors comments/Treatment: Excellent/stable/enhancement _____

D: _____ M: _____ Y: _____

OD Signature _____