BURLINGTON
LASER EYE CENTRE

PRK POST - OPERATIVE FORM

Tel: 888-636-4733 • Fax: 1-855-361-9995

Name: ______ Age: ______ Tx: PRK ☐OD ☐OS ☐OU

Co-Managing Doctor: ______ Doctor Phone: ______ Doctor Email: ______

Original Treatment Date: ______ Postoperative Visit: Day ______ / Week ______ / Month ______

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 /
SLIT LAMP	CORNEAL CLARITY HAZE GRADE: ☐ Clear ☐ Trace Reticular ☐ Mild Reticular ☐ Moderate Confluent ☐ Severe Confluent HAZE PATTERN: ☐ Diffuse ☐ Focal ☐ Arcuate	CORNEAL CLARITY HAZE GRADE: ☐ Clear ☐ Trace Reticular ☐ Mild Reticular ☐ Moderate Confluent ☐ Severe Confluent HAZE PATTERN: ☐ Diffuse ☐ Focal ☐ Arcuate
IOP	mmHg	mmHg

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

Doctors comments / Treatment: excellent / stable / enhancement ______