Post-operative assessment: LASIK and ASL (PRK)

Conlon Eye Institute
Medical Arts Building, 341-750 Spadina Crescent East, Saskatoon SK S7K 3H3
Phone (306) 244-4111 Fax (306) 244-9904 referrals@conloneyeinstitute.com
Monday to Friday, 7 am to 4 pm

Confidential. Personal health information.

Follow-up visits vary by procedure. When the patient returns to your care, we send a surgery report and post-op guidelines.

PATIENT AND THIS VISIT

Procedure (tick one): ☐ LASIK ☐ ASL (PRK)

Patient name: _____ Date of birth: _____ Chart or health number: _____

Eye(s) treated: ☐ OD ☐ OS ☐ Both Date of procedure: _____ Date of this exam: _____ Next appointment: _____

Visit interval: _____ days _____ weeks _____ months Other: _____

Typical visit (tick one). These are typical and may vary.

☐ Day 1 ☐ 1 week ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other _____

OD (right)

☐ Retreat

Complete for each eye examined.

UCVA 20/_____ UCNVA 20/_____ IOP _____ mmHg

Manifest refraction M _____ _____ x _____ 20/_____

BCVA 20/_____

Describe findings. Leave blank if not examined.

Flap position and edge (LASIK): _____

ASL (PRK) epithelium and healing: _____

Interface: _____

Cornea (including any infiltrate): _____

Anterior chamber: _____

Other: _____

Medication: _____

Plan and comments: _____

OS (left)

☐ Retreat

Complete for each eye examined.

UCVA 20/_____ UCNVA 20/_____ IOP _____ mmHg

Manifest refraction M _____ _____ x _____ 20/_____

BCVA 20/_____

Describe findings. Leave blank if not examined.

Flap position and edge (LASIK): _____

ASL (PRK) epithelium and healing: _____

Interface: _____

Cornea (including any infiltrate): _____

Anterior chamber: _____

Other: _____

Medication: _____

Plan and comments: _____

SEND BACK TO US RIGHT AWAY

Tick any that apply, then phone (306) 244-4111 and fax this form.

☐ Signs of infection after surgery (increasing pain, reduced vision or hypopyon)
☐ IOP above 40
☐ Corneal infiltrate after laser
☐ Displaced LASIK flap
☐ ASL (PRK) surface not healed by day 7
☐ Other concern, specify: _____

OPTOMETRIST

Name: _____ Billing number: _____ Clinic: _____

Phone: _____ Fax: _____ Email: _____ Signature: _____ Date: _____

Fax completed form to (306) 244-9904. Do not email patient information unless secure.