PRK Post-op Evaluation (Form d)

Patient Information
Last Name ______________________________ First Name ________________________

Co-managing Doctor ____
e-mail Phone Fax

Right Eye Information

Procedure Date Month ____________ Day ________ Year ________________

Procedure Type Custom PRK / Conventional PRK / Repeat PRK

Original Rx ____________________

Enhance Rx ____________________

Original BCVA _20/_____________ **Age** _______ **Target** Plano Mono

Right Eye Exam

Date Month ____________ Day ________ Year ________________

Circle Day ________ Week 1 2 3 Month 1 2 3 4 5 6 9 12

Meds Zymar Lubrication ________________________________

Pred Forte / FML QID TID BID QD Q2D Nil

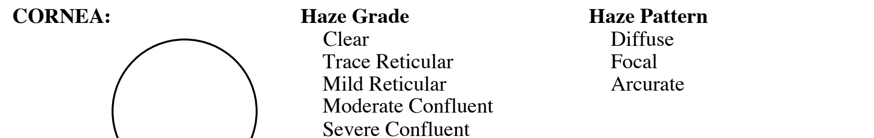
Auto Refraction ____

UCVA 20/ blurry glare double fluctuates

Refraction ____

Symptoms ____

CORNEA:



Haze Grade
Clear
Trace Reticular
Mild Reticular
Moderate Confluent
Severe Confluent

Haze Pattern
Diffuse
Focal
Arcurate

IOP (applanation) ________________ mm

Treatment Pred Forte / FML QID TID BID QD Q2D Nil

Lubrication ______________________________

Doctor Comments excellent stable enhancement

Enhancement myoia hyperopia cylinder epithelial ingrowth central island
GVL to contact patient Patient will call GVL

Follow-up with co-managing doctor with GVL

Next Visit In 1 2 3 4 5 6 days weeks months

Comments ____

Left Eye Information

Procedure Date Month ____________ Day ________ Year ________________

Procedure Type Custom PRK / Conventional PRK / Repeat PRK

Original Rx ____________________

Enhance Rx ____________________

Original BCVA _20/_____________ **Age** _______ **Target** Plano Mono

Left Eye Exam

Date Month ____________ Day ________ Year ________________

Circle Day ________ Week 1 2 3 Month 1 2 3 4 5 6 9 12

Meds Zymar Lubrication ________________________________

Pred Forte / FML QID TID BID QD Q2D Nil

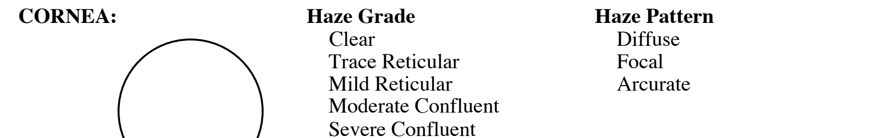
Auto Refraction ____

UCVA 20/ blurry glare double fluctuates

Refraction ____

Symptoms ____

CORNEA:



Haze Grade
Clear
Trace Reticular
Mild Reticular
Moderate Confluent
Severe Confluent

Haze Pattern
Diffuse
Focal
Arcurate

IOP (applanation) ________________ mm

Treatment Pred Forte / FML QID TID BID QD Q2D Nil

Lubrication ______________________________

Doctor Comments excellent stable enhancement

Enhancement myoia hyperopia cylinder epithelial ingrowth central island
GVL to contact patient Patient will call GVL

Follow-up with co-managing doctor with GVL

Next Visit In 1 2 3 4 5 6 days weeks months

Comments ____

PRK Post-op Continuation (Form e)

Patient Information
Last Name ______________________ First Name ______________________

Co-managing Doctor ______________________
e-mail Phone Fax

Right Eye Information

Procedure Date Month ____________ Day ________ Year ______________

Procedure Type Custom PRK / Conventional PRK / Repeat PRK
Original Rx ______________
Enhance Rx ______________

Original BCVA _20/__________ **Age** ______ **Target** Plano Mono

Right Eye Exam

UCVA: 20/ ________ **Day** __________

MEDS: BCL, Antibiotic, Steroid:, NSAID, Patch ung _____, Other:

FINDINGS: BCL: Yes Lost / Tight Fit Ok Loose / Infiltrate: Yes No
Healed ________%
Edema ________/4+
Pain __________/10

TREATMENT: Same drops / Patch ung _____ / BCL removed / New BCL / ____________ / ____________

UCVA: 20/ ________ **Day** __________

MEDS: BCL, Antibiotic, Steroid:, NSAID, Patch ung _____, Other:

FINDINGS: BCL: Yes Lost / Tight Fit Ok Loose / Infiltrate: Yes No
Healed ________%
Edema ________/4+
Pain __________/10

TREATMENT: Same drops / Patch ung _____ / BCL removed / New BCL / ____________ / ____________

UCVA: 20/ ________ **Day** __________

MEDS: BCL, Antibiotic, Steroid:, NSAID, Patch ung _____, Other:

FINDINGS: BCL: Yes Lost / Tight Fit Ok Loose / Infiltrate: Yes No
Healed ________%
Edema ________/4+
Pain __________/10

TREATMENT: Same drops / Patch ung _____ / BCL removed / New BCL / ____________ / ____________

Left Eye Information

Procedure Date Month ____________ Day ________ Year ______________

Procedure Type Custom PRK / Conventional PRK / Repeat PRK
Original Rx ______________
Enhance Rx ______________

Original BCVA _20/__________ **Age** ______ **Target** Plano Mono

Left Eye Exam

UCVA: 20/ ________ **Day** __________

MEDS: BCL, Antibiotic, Steroid:, NSAID, Patch ung _____, Other:

FINDINGS: BCL: Yes Lost / Tight Fit Ok Loose / Infiltrate: Yes No
Healed ________%
Edema ________/4+
Pain __________/10

TREATMENT: Same drops / Patch ung _____ / BCL removed / New BCL / ____________ / ____________

UCVA: 20/ ________ **Day** __________

MEDS: BCL, Antibiotic, Steroid:, NSAID, Patch ung _____, Other:

FINDINGS: BCL: Yes Lost / Tight Fit Ok Loose / Infiltrate: Yes No
Healed ________%
Edema ________/4+
Pain __________/10

TREATMENT: Same drops / Patch ung _____ / BCL removed / New BCL / ____________ / ____________

UCVA: 20/ ________ **Day** __________

MEDS: BCL, Antibiotic, Steroid:, NSAID, Patch ung _____, Other:

FINDINGS: BCL: Yes Lost / Tight Fit Ok Loose / Infiltrate: Yes No
Healed ________%
Edema ________/4+
Pain __________/10

TREATMENT: Same drops / Patch ung _____ / BCL removed / New BCL / ____________ / ____________