Laser Vision Correction Assessment

re:vision
Laser & Cataract

Attention: ◯ Dr Trevor Gray ◯ Dr Mo Ziaei

Re:Vision Reference Number ______________ Assessment Date ______________

Patient Name ______________ Referring Optometrist ______________

Address ______________ Address ______________

______________ ______________

DOB ______________ Phone ______________

Phone - Work ______________ Home ______________ Mobile ______________

Email ______________

Date of Surgery ______________

Follow-up interval ◯ 1 week ◯ 6 week ◯ Other ______________

Examination

	Right (OD)	Left (OS)
Unaided visual acuity	6/	6/
Binocular unaided visual acuity	Distance 6/	Near
Near vision - if appropriate	N	N
Subjective refraction + BSCVA	6/	6/
Corneal examination WG-LASIK	◯ Dryness (SPK) 0-5 ◯ Wrinkles ◯ Epithelial ingrowth ◯ Interface debris	◯ Dryness (SPK) 0-5 ◯ Wrinkles ◯ Epithelial ingrowth ◯ Interface debris
Smart surface / PRK / PTK	◯ Haze (grade 0-5) ◯ Epithelial coverage% ◯ Other ______	◯ Haze (grade 0-5) ◯ Epithelial coverage% ◯ Other ______

Comments ______________

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Patient Satisfaction ◯ Very happy ◯ Happy ◯ Neutral ◯ Unhappy ◯ Dissatisfied

List medication to be continued ______________

Next follow-up appointment ______________ ◯ Disharged

◯ Surgeon to call optometrist ◯ Surgeon to call patient ◯ Refer back to refractive surgeon

Signed ______________ Date ______________