

POST-OPERATIVE REFRACTIVE ASSESSMENT



EYE INSTITUTE

Attention: Dr Gray Dr Mantell Dr Morris Dr Ring Dr Watson

EYE INSTITUTE reference number _____ Assessment Date _____

Patient's Name _____ Referring Optometrist _____

Address _____ Address _____

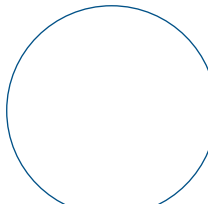
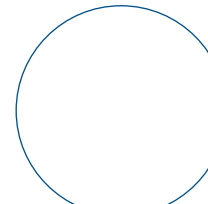
DOB _____ Phone _____

Phone (h) _____ (w) _____ (mobile) _____

Date of Surgery _____

Follow-up interval (circle) 1 week 1 month 3 months Other _____

EXAMINATION

	Right (OD)	Left (OS)
Unaided visual acuity	6/	6/
Binocular unaided visual acuity	6/	
Near vision - if appropriate	N	N
Subjective refraction		
Best corrected visual acuity (BCVA)	6/	6/
Corneal examination	<input type="checkbox"/> Dryness (SPK)  <input type="checkbox"/> Wrinkles <input type="checkbox"/> Epithelial ingrowth <input type="checkbox"/> Interface debris <input type="checkbox"/> Haze (grade 1-4) <input type="checkbox"/> Other _____	<input type="checkbox"/> Dryness (SPK)  <input type="checkbox"/> Wrinkles <input type="checkbox"/> Epithelial ingrowth <input type="checkbox"/> Interface debris <input type="checkbox"/> Haze (grade 1-4) <input type="checkbox"/> Other _____

COMMENTS

EYE INSTITUTE FEEDBACK

PATIENT SATISFACTION Very Happy Happy Neutral Unhappy Dissatisfied

List medication to be continued _____

Next follow up appointment _____ Discharged

Surgeon to call optometrist Refer back to refractive surgeon

Signed _____ Date _____

Please forward your invoice for your professional services to **info@eyeinstitute.co.nz**.
 Please ensure that when invoicing Eye Institute, the patient is aware that Eye Institute will cover their assessment fees.