Post-Operative Refractive 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	6/	
Near vision - if appropriate	N	N
Subjective refraction		
Best corrected visual acuity (BCVA)	6/	6/
Corneal examination	◯ Dryness (SPK) ◯ Wrinkles ◯ Epithelial ingrowth ◯ Interface debris ◯ Haze (grade 1-4) ◯ Other ______	◯ Dryness (SPK) ◯ Wrinkles ◯ Epithelial ingrowth ◯ Interface debris ◯ Haze (grade 1-4) ◯ Other ______

Comments

Re:Vision 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 ______________________