Laser Vision Correction Quality Assurance
1 DAY POST-OP REPORT

Pacific CATARACT AND LASER INSTITUTE

To help us maintain the highest quality surgical outcomes, we appreciate information from your 1-day post-operative exam. Please complete and mail this form at your earliest convenience.

Thank you for sharing your exam findings.

Patient's Name _____ **DOB** _____ **Date of Exam** _____

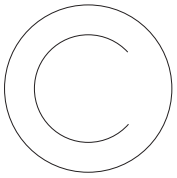
Type of Surgery ☐ LASIK ☐ Surface laser vision correction

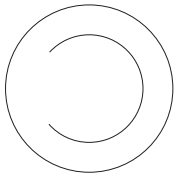
SUBJECTIVE _____

_____

_____

OBJECTIVE	**RIGHT EYE**	**LEFT EYE**
Date of Surgery	_____	_____
Uncorrected VA	20/_____	20/_____
Best Corrected VA	20/_____ (optional)	20/_____ (optional)
Manifest Refraction	_____ - _____ x _____ 20/_____	_____ - _____ x _____ 20/_____
Conjunctiva	☐ clear ☐ other_____	☐ clear ☐ other_____
Cornea:		
Cap Position	☐ centered ☐ other_____	☐ centered ☐ other_____
Epithelial Surface	☐ clear ☐ other_____	☐ clear ☐ other_____
Haze	☐ normal ☐ other_____	☐ normal ☐ other_____
Interface	☐ clear ☐ other_____	☐ clear ☐ other_____
Fluorescein	☐ normal ☐ other_____	☐ normal ☐ other_____





Anterior Chamber ☐ clear ☐ other_____ ☐ clear ☐ other_____

ASSESSMENT _____

_____

_____

PLAN _____

_____

_____

Comments _____

_____

_____

Please contact us by telephone if you require assistance with any post-operative condition.

Physician Name _____ Signature _____

Please Print

Top copy—for your records. Back copy—mail to PCLI or fax to (360) 807-7689. Do not staple.

09/16