Laser Vision Correction Quality Assurance
1 WEEK–6 MONTH POST-OP REPORT

To help us maintain the highest quality surgical outcomes, we appreciate information from your 1-week, 1-month and 6-month post-operative exams. Items listed in **bold** are data we request for our outcomes database—other data is optional. 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 ______________

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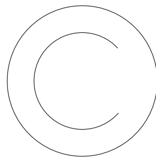
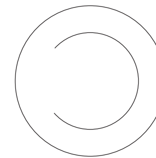
OBJECTIVE	**RIGHT EYE**			**LEFT EYE**		
Date of Surgery	______________			______________		
This Post-op Visit	☐ 1 week	☐ 1 month	☐ 6 month	☐ 1 week	☐ 1 month	☐ 6 month
Uncorrected VA	20/______			20/______		
Best Corrected VA	20/______ (optional)			20/______ (optional)		
Manifest Refraction	______ - ______ x ______ 20/______			______ - ______ x ______ 20/______		
K's ☐ manual ☐ auto	______ - ______@______			______ - ______@______		
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 ______	





	RIGHT EYE		LEFT EYE	
Anterior Chamber	☐ clear	☐ other ______	☐ clear	☐ other ______
IOP ☐ air ☐ applanation	______ mm Hg @ ______		______ mm Hg @ ______	

ASSESSMENT ______________

PLAN ______________

How do you rate this patient's satisfaction? ☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very Dissatisfied

Comments ______________

Please contact us by telephone if you need 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