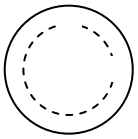
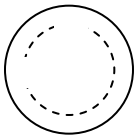
Comanaging Doctor
Postoperative Refractive Surgery Report

Patient Name:		CEA Chart #:
Address:		Date of Birth:
City:	State:	Zip:
Surgery Date:	Surgeon:	

Post operative Exam Date:	Co-Managing Doctor:
Procedure OD: ☐ LASIK ☐ CRI ☐ PRK ☐ Enhancement ☐ ICL ☐ Refractive Lensectomy	**Procedure OS:** ☐ LASIK ☐ CRI ☐ PRK ☐ Enhancement ☐ ICL ☐ Refractive Lensectomy
Patient's Subjective Statement:	
Manifest Refraction OD:	**Manifest Refraction OS:**
Vision Distance SC: OD CC: OD	Vision Distance SC: OS CC: OS
Vision Near SC: OD CC: OD	Vision Near SC: OS CC: OS
Slit Lamp Cornea OD	**Slit Lamp Cornea OS**
	
For CRI, ICL & Refractive Lensectomy Patients Only	**For CRI, ICL & Refractive Lensectomy Patients Only**
Anterior Chamber:	Anterior Chamber:
Lens:	Lens:
Incision: ☐ Normal ☐ Seidel+ ☐ Infiltrate	Incision: ☐ Normal ☐ Seidel+ ☐ Infiltrate

Assessment:

Plan:

Medications:

Return for Follow up:	Doctor Signature:

FAX form to 910-295-5526