

Spivack Vision Center®

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Post Surgical Evaluation Form

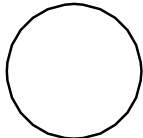
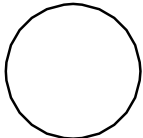
Exam Date: ___/___/___
 Co-managing Doctor: _____
 Co-managing Doctor's Phone Number: _____
 Co-managing Doctor's Fax: _____

Patient's Name _____ CLS ID# _____
Last First Mid Init.

Date of Surgery: _____ Surgeon: _____

RIGHT EYE	LEFT EYE
Pre-Op Rx: _____ 20/____ ___ PRK ___ LASIK ___ Enh ___ PTK	Pre-Op Rx: _____ 20/____ ___ PRK ___ LASIK ___ Enh ___ PTK
Surgical Goal: ___ Plano ___ Mono: _____ D	Surgical Goal: ___ Plano ___ Mono: _____ D
Post op Duration: ___ day(s) ___ week(s) ___ mo(s) ___ year(s)	Post op Duration: ___ day(s) ___ week(s) ___ mo(s) ___ year(s)

Comments/Meds:

UCVA: 20/ _____ PH: _____	UCVA: 20/ _____ PH: _____ (OU: 20/____)
MRx: _____ 20/____	MRx: _____ 20/____
Cyclo (if appl.): _____ 20/____	Cyclo (if appl.): _____ 20/____
Epithelium: Clear Ingrowth SPK Edema	Epithelium: Clear Ingrowth SPK Edema
Flap: Clear Positioned Striae Edema Haze other:	Flap: Clear Positioned Striae Edema Haze other:
Interface: Clear Debris Haze	Interface: Clear Debris Haze
Stromal Haze (PRK): None Focal Diffuse Reticular	Stromal Haze (PRK): None Focal Diffuse Reticular
IOP	IOP
Schematic: (Anterior Seg/Fundus) 	Schematic: (Anterior Seg/Fundus) 

Impression:

Plan:

Doctor Sig: _____ Date: _____