BURLINGTON
LASER EYE CENTRE

PRK POST - OPERATIVE FORM

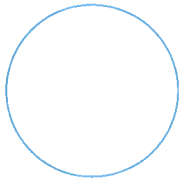
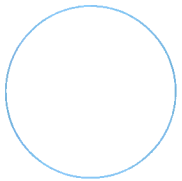
Tel: 888-636-4733 • Fax: 1-855-361-9995

Name: _____ **Age:** _____ **Tx:** PRK ☐OD ☐OS ☐OU

Co-Managing Doctor: _____ **Doctor Phone:** _____ **Doctor Email:** _____

Original Treatment Date: _____ **Postoperative Visit:** Day _____ / Week _____ / Month _____

Meds / Dosage: Pred Forte _____ / FML 0.1 _____ / Zymar _____ / Artificial Tears: PF / Regular _____

	OD Target: Plano / Other: _____	OS Target: Plano / Other: _____
UCDVA	20 / (blurry / glare / dbl / fluctuates)	20 / (blurry / glare / dbl / fluctuates)
Refraction	20 /	20 /
SLIT LAMP	CORNEAL CLARITY  HAZE GRADE ☐ Clear ☐ Trace Reticular ☐ Mild Reticular ☐ Moderate Confluent ☐ Severe Confluent HAZE PATTERN ☐ Diffuse ☐ Focal ☐ Arcuate	CORNEAL CLARITY  HAZE GRADE ☐ Clear ☐ Trace Reticular ☐ Mild Reticular ☐ Moderate Confluent ☐ Severe Confluent HAZE PATTERN ☐ Diffuse ☐ Focal ☐ Arcuate
IOP	mmHg	mmHg

Next followup visit scheduled: _____ day / week / month / year **Followup required with BLEC:** Y N

Doctors comments / Treatment: excellent / stable / enhancement _____

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