



Kelowna Laser Vision inc.

Patient _____ DOB _____ Date of Exam _____

Surgery: PRK LASIK P/o appt. 3d 1wk 1mos 3mos 6mos (PRK) 1yr (PRK) other _____

Patient Comments: _____

Medications (type and frequency) _____

Artificial Tears (type and frequency) _____

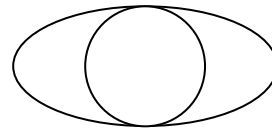
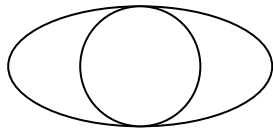
UCVA OD Distance 20/____ OS Distance 20/____
OD Near 20/____ OS Near 20/____
(if mono) (if mono)

Subj. Refraction OD _____ 20/____ OS _____ 20/____

Auto-Refraction OD _____ OS _____

IOP OD _____ OS _____
(if on steroids)

Slit Lamp Exam



Clear 0+ 1+ 2+ 3+ 4+ SPK Clear 0+ 1+ 2+ 3+ 4+
Clear 0+ 1+ 2+ 3+ 4+ Edema Clear 0+ 1+ 2+ 3+ 4+
Clear 0+ 1+ 2+ 3+ 4+ Haze (PRK) Clear 0+ 1+ 2+ 3+ 4+
Clear 0+ 1+ 2+ 3+ 4+ Interface (Lasik) Clear 0+ 1+ 2+ 3+ 4+
Clear 0+ 1+ 2+ 3+ 4+ Striae (Lasik) Clear 0+ 1+ 2+ 3+ 4+

Dr.'s Comments to Patient _____

Dr.'s Plan _____

Changes to meds (type and frequency) _____

Changes to art. tears (type and frequency) _____

Next Appt: _____ Co-Manager OD/Clinic _____

☐ Please contact me regarding this patient Phone _____ Fax _____