Post-Operative Refractive Assessment

re:vision
Anterior Segment Specialists

Attention: ◯ Dr Trevor Gray ◯ Dr Mo Ziaei

Re:Vision Reference Number _____ Assessment Date _____

Patient Name _____ Referring Optometrist _____

Address _____ Address _____

_____ _____

DOB _____ Phone _____

Phone - Work _____ Home _____ Mobile _____

Email _____

Date of Surgery _____

Follow-up interval ◯ 1 week ◯ 1 month ◯ 3 months ◯ Other _____

Examination

	Right (OD)	Left (OS)
Unaided visual acuity	6/	6/
Binocular unaided visual acuity	6/	
Near vision - if appropriate	N	N
Subjective refraction		
Best corrected visual acuity (BCVA)	6/	6/
Corneal examination	◯ Dryness (SPK) ◯ Wrinkles ◯ Epithelial ingrowth ◯ Interface debris ◯ Haze (grade 1-4) ◯ Other _____	◯ Dryness (SPK) ◯ Wrinkles ◯ Epithelial ingrowth ◯ Interface debris ◯ Haze (grade 1-4) ◯ Other _____

Comments

Re:Vision Feedback

Patient Satisfaction ◯ Very happy ◯ Happy ◯ Neutral ◯ Unhappy ◯ Dissatisfied

List medication to be continued _____

Next follow-up appointment _____ ◯ Disharged

◯ Surgeon to call optometrist ◯ Refer back to refractive surgeon

Signed _____ Date _____

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