INSIGHT VISION GROUP

LASIK Post-Op Evaluation

Referring Doctor:_____

Please FAX completed form to:
Parker: 720.880.6460
Boulder: 303.593.2199
Littleton: 303.991.9647

Name (First/Last):	DOB:	Surgery Date: Primary / Enhancement

Exam Data

		OD			OS		
		Goal:			**Goal:**		
	History	Happy	Unsure	Unhappy	Happy	Unsure	Unhappy
1 Day	**Meds**			AT's ____ x a day			AT's _____ x a day
10 Day	**Acuity**	UCVA 20/			UCVA 20/		UCVA OU 20/
2 Mo	**Refraction**			20/			20/
Other:							
_____	**Flap**	Good SPK Debris Straie DLK EI Other: _____			Good SPK Debris Straie DLK EI Other: _____		
	Assessment	Good	Unsure	Enhance	Good	Unsure	Enhance
	Plan	RTC		InS CoMg	RTC		InS CoMg

Notes:

Today's Date_____ Doctor's Signature

Exam Data

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	History	Happy	Unsure	Unhappy	Happy	Unsure	Unhappy
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	Assessment	Good	Unsure	Enhance	Good	Unsure	Enhance
	Plan	RTC		InS CoMg	RTC		InS CoMg

Notes

Today's Date_____ Doctor's Signature