



INSIGHT VISION GROUP

LASIK Post -Op Evaluation

Referring Doctor : _____

Please FAX completed form to :

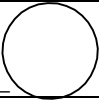
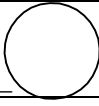
Parker: 720.880.6460

Boulder: 303.593.2199

Littleton: 303.991.9647

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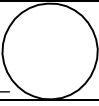
Exam Data

	OD	OS	
1 Day 10 Day 2 Mo Other: _____	Goal:	Goal:	
	History	Happy Unsure Unhappy	Happy Unsure Unhappy
	Meds	AT's ____ x a day	AT's ____ x a day
	Acuity	UCVA 20/	UCVA 20/
	Refraction	20/	20/
	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

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

Notes

Today's Date _____ Doctor's Signature _____