INSIGHT VISION GROUP

PRK/ASA 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:

Exam Data

		OD			OS		
1 Day	Goal:				Goal:		
3 Day	History	Happy	Unsure	Not Happy	Happy	Unsure	Not Happy
10 Day	Meds			AT's ____ x a day			AT's ____ x a day
1 Mo	Acuity	UCVA 20/			UCVA 20/		UCVA OU 20/
3 Mo	Refraction			20/			20/
6 Mo				20/			20/
Other:	Cornea						
_____	Assessment	Good	Unsure	Enhance	Good	Unsure	Enhance
	Plan	RTC		InS CoMg	RTC		InS CoMg

Doctor's Signature:	Notes:	IOP @ _____
Today's Date _____		OD _____
		OS _____

Exam Data

		OD			OS		
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Doctor's Signature:	Notes:	IOP @_____
Today's Date _____		OD _____
		OS _____