

**POST OPERATIVE FORM FOR** **REFRACTIVE LASER SURGERY**

Patient Name: ........................................................................................ DOB:………/…………/……..

Date of Surgery: ............../ .............../ .....................

Date of examination: ..............................Please tick: 1 month 3 months 6 months

**Visual acuity:** Right Left

Uncorrected .................... ......................

Corrected .................... ......................

**Subjective Refraction:** Right Left

.............................**DS** ………………………..**DS**

DC Ax DC Ax

**Keratometry reading:**

Right: Left:

Flattest Steepest Steepest Axis Flattest Steepest Steepest Axis

................D .................D ........................... ................D .................D ...........................

**Slit Lamp Examination:** Right Left:

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Comments:

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NVC Office Use:

Referring Optometrist: .................................................

Company: ......................................................................

Address: .........................................................................

Tel No. ...............................

Email:………………………………………………………………………..

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