



**The Eye Center**  
OF SOUTHERN INDIANA  
**Refractive Surgery Post-Op**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Comanaging Doctor: \_\_\_\_\_

OD: \_\_\_\_\_ OD: \_\_\_\_\_ OD: \_\_\_\_\_

Surgery Date: \_\_\_\_\_ Enhancement: \_\_\_\_\_ Pre-Op Cyclo \_\_\_\_\_

OS: \_\_\_\_\_ OS: \_\_\_\_\_ OS: \_\_\_\_\_

Refractive Goal: OD: Plano Other \_\_\_\_\_ OS: Plano Other \_\_\_\_\_

**History**

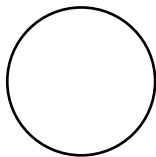
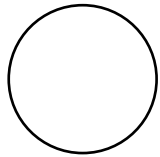
Date: \_\_\_\_\_

OD 20/\_\_\_\_\_  
VAsc OU 20/\_\_\_\_\_  
OS 20/\_\_\_\_\_

OD \_\_\_\_\_ 20/\_\_\_\_\_

OS \_\_\_\_\_ 20/\_\_\_\_\_

SLEx: IOP: \_\_\_\_\_ OS  
OD



**Assessment**

Satisfaction Rating: \_\_\_\_/10

**Plan**

Follow up: EC OD's office

In: \_\_\_\_Days \_\_\_\_Weeks \_\_\_\_Months

For: MR CR Orb TA WS Other: \_\_\_\_\_

Fax this to The Eye Center 812-333-5039

**Signed:**

**History**

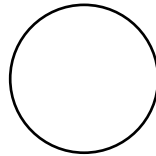
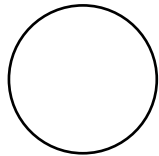
Date: \_\_\_\_\_

OD 20/\_\_\_\_\_  
VAsc OU 20/\_\_\_\_\_  
OS 20/\_\_\_\_\_

OD \_\_\_\_\_ 20/\_\_\_\_\_

OS \_\_\_\_\_ 20/\_\_\_\_\_

SLEx: IOP: \_\_\_\_\_ OS  
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**Signed**