

**Postoperative Assessment Form for Laser Vision  
Correction**  
**Wellington Eye Centre**

**Patient details:**

Fullname	<input type="text"/>	Date of birth	<input type="text"/>
Contact phone	<input type="text"/>	Date of surgery	<input type="text"/>
Address	<input type="text"/>	Date of this examination	<input type="text"/>
		Visit (eg; 1 week, 1 / 3 /6 month)	<input type="text"/>
Patient satisfaction scale (0=very unhappy, 10=very happy)		<input type="text"/>	

Patient's comments or concerns:

Examining optometrist's concerns or questions for Wellington Eye Centre:

**Clinical Examination**

	OU distance	OU near	Right Eye	Left Eye
<b>ACUITY &amp; REFRACTION</b>				
Uncorrected acuity	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Distance Refraction			<input type="text"/>	<input type="text"/>
Best Corrected Acuity			<input type="text"/>	<input type="text"/>
<b>CORNEAL &amp; CONJUNCTIVAL APPEARANCE</b>				
Corneal epithelium intact? SPK?			<input type="text"/>	<input type="text"/>
Corneal epithelium clear / regular?			<input type="text"/>	<input type="text"/>
Any stromal haze or scarring?			<input type="text"/>	<input type="text"/>
Tear Break Up Time			<input type="text"/>	<input type="text"/>

**VISUAL PERFORMANCE**

Any monocular diplopia?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Any night vision issues?	<input type="text"/>	<input type="text"/>	<input type="text"/>

**OCCULAR COMFORT**

Dry or gritty eyes	<input type="text"/>	<input type="text"/>	<input type="text"/>
Catching sensation on waking?	<input type="text"/>	<input type="text"/>	<input type="text"/>

Every laser vision correction patient has had a dilated retinal examination with Dr Logan within 12 months of their surgery. We do not need posterior ocular health assessments, unless you find unexplained reduced best corrected vision. We do not require retinal photographs, posterior OCT or topography unless indicated. If you would like more clinical information, eg IOPs or Posterior findings, please email [info@wefixeyes.co.nz](mailto:info@wefixeyes.co.nz)

Examining optometrist's advice to patient (any changes to eye drops, next review):

Referring Optometrist’s name, email and practicedetails:

Please return this form by email,  
post if email is not possible.

**[info@wefixeyes.co.nz](mailto:info@wefixeyes.co.nz)**

Wellington Eye Centre  
Level 4, 148 Cuba Street  
Wellington, 6011

Thank you for your care of our mutual patient. If you have any questions, please don’t hesitate contact us on **0800 733 327**