Post-Operative Assessment Form for Laser Vision Correction

Wellington Eye Centre

Patient details:							
Full name			Email address				
Contact phone			Date of birth				
Address			Date of examinat	ion			
			Visit (eg; 1 week, 1/3/6 month)				
Patient satisfaction so	cale (0 = very unha _l	ppy, 10 = very h	арру)				
Patient's comments of	or concerns:						
Examining optometris	st's concerns or que	estions for Welli	ngton Eye Centre:				
Clinical Examination ACUITY & REFRACTION							
	OU distance	OU near	Right Eye		Left Eye		
Uncorrected acuity							
Distance Refraction		[
Best Corrected Acuit	у	[
CORNEAL & CON	JUNCTIVAL APP	EARANCE					
Please describe if preser SPK	ıt:	[
Corneal epithelium c	lear / regular?						
Any stromal haze or	scarring?	[
Tear Break Up Time							

VISUAL PERFORMANCE	Yes/No and comments:						
Any diplopia?							
Any night vision issues?							
OCCULAR COMFORT	Yes/No	Right Eye	Left Eye				
Dry or gritty eyes		Ţ,	,				
Catching sensation on waking?							
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 Examining optometrist's advice to patient (any changes to eye drops, next review):							
Reporting Optometrist's details:							
Name:		Please return this form by email:					
Practice Name:		info@wefixeyes.co.nz					
Email address:		Wellington Eye Centre					
		Level 4, 148 Cuba	Street				
		Wellington, 6011					