

**Laser Eye Surgery
Hamilton**



Post operative report following refractive surgery

Patients Name		Name of Referrer	
Address		Practice	
		Address	
Home phone			
Business/mobile phone		Phone	
Date of birth: / /			
Occupation		Fax	
Date of assessment: / /		Date of surgery: / /	Surgery Type:
1 week 1 month 3 month 6 month (if required) Other			
	Right Eye		Left Eye
Uncorrected VA	6/		6/
Refraction		6/	6/
Pinhole	6/		6/
Near VA (Monovision)	N		N
IOP 3/12 postop.	mmHg @		mmHg @
Slit Lamp Examination			
Epithelium Flap Edge Interface			
Comments:			
Patient Satisfaction:	Very Happy 5 4 3 2 1 Unhappy		
Comments:			
Directions given to Patient:			
Patient Medications:			
Questions to surgeon/Additional comments:			
Surgeon to ring Optometrist		Refer back to surgeon for review	
Signed Referring Practitioner:		Date:	

For prompt and correct payment for this report ensure that your practice details are accurate and that an invoice is attached with report, whether faxing or posting. Please see fee for service policy.