

# Refractive Surgery Co-Management Exam Form

SEA Record of Medical Care

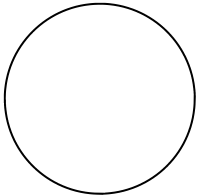
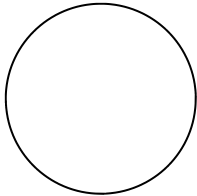


Patient's Name: \_\_\_\_\_ Tech: \_\_\_\_\_ Page#: \_\_\_\_\_

Post-Op / Procedure: \_\_\_\_\_ 1 wk / 1 mo / 3 mos / 6 mos / \_\_\_\_\_ Other: \_\_\_\_\_ OD / OS / OU Treatment Date: \_\_\_\_\_

History: \_\_\_\_\_

Ocular Medications: \_\_\_\_\_

OD	VA SC	OS
20/_____ Distance	Distance 20/_____ OU	Distance 20/_____
20/_____ Pinhole	Near 20/_____ OU	Pinhole 20/_____
20/_____ OD	<b>MR</b>	OS _____ 20/_____
_____ Atch OD	<b>TOPO</b>	OS Atch _____
Clear _____ @ _____ OD	<b>K's</b>	OS _____ @ _____ Clear
Distorted _____ @ _____ OD	<b>IOP</b>	OS _____ @ _____ Distorted
@ _____ am / pm _____ mmHg PEN / TAG OD		OS TAG / PEN _____ mmHg @ _____ am / pm
Bandage CL? <input type="checkbox"/> YES <input type="checkbox"/> NO		Bandage CL? <input type="checkbox"/> YES <input type="checkbox"/> NO
		
_____ Dislodged / Striae / Centered OD	<b>POSITION</b>	OS Centered / Striae / Dislodged _____
_____ Edema / Haze / Clear OD	<b>CLARITY</b>	OS Clear / Haze / Edema _____
_____ Opacities / Epith Ingrowth / Clear OD	<b>INTERFACE</b>	OS Clear / Epith Ingrowth / Opacities _____
_____ Rolled / Eroded / Smooth OD	<b>EDGES</b>	OS Smooth / Eroded / Rolled _____
_____ SPK / Irregular / Intact OD	<b>EPITHELIUM</b>	OS Intact / Irregular / SPK _____

**IMPRESSION**

---

**PLAN**

---

**Patient Satisfaction:** Happy?  YES  NO    Unhappy?  YES  NO    Reassured?  YES  NO

Eye Care Provided By: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Please Fax to Southern Eye Associates at (901) 255-5612**