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	**MR**	OS _______________ 20/_______
_______________ Attch OD	**TOPO**	OS Attch _______________
Clear _______________ @ _______ OD	**K's**	OS _______________ @ _______ Clear
Distorted _______________ @ _______ OD		OS _______________ @ _______ Distorted
@ _______ am / pm _______ mmHg PEN / TAG OD	**IOP**	OS TAG / PEN _______ mmHg @ _______ am / pm
Bandage CL? ☐ YES ☐ NO		Bandage CL? ☐ YES ☐ NO

OD		OS
_______________ Dislodged / Striae / Centered OD	**POSITION**	OS Centered / Striae / Dislodged _______________
_______________ Edema / Haze / Clear OD	**CLARITY**	OS Clear / Haze / Edema _______________
_______________ Opacities / Epith Ingrowth / Clear OD	**INTERFACE**	OS Clear / Epith Ingrowth / Opacities _______________
_______________ Rolled / Eroded / Smooth OD	**EDGES**	OS Smooth / Eroded / Rolled _______________
_______________ SPK / Irregular / Intact OD	**EPITHELIUM**	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