INSIGHT VISION GROUP

# PRK/ASA Post-Op Evaluation

Referring Doctor: ______________________

Please FAX completed form to:

Parker: 720.880.6460

Boulder: 303.593.2199

| Name (First/Last): | DOB: | Surgery Date: |
|---|---|---|

## Exam Data

| | | OD | | | OS | | |
|---|---|---|---|---|---|---|---|
| 1 Day<br>3 Day<br>10 Day<br>1 Mo<br>3 Mo<br>6 Mo<br>Other:<br>______ | Goal: | | | | Goal: | | |
| | **History** | Happy | Unsure | Not Happy | Happy | Unsure | Not Happy |
| | **Meds** | | | AT's ____ x a day | | | AT's ____ x a day |
| | **Acuity** | UCVA 20/ | | | UCVA 20/ | | UCVA OU 20/ |
| | **Refraction** | | | 20/ | | | 20/ |
| | | | | 20/ | | | 20/ |
| | **Cornea** | | | ○ | | | ○ |
| | **Assessment** | Good | Unsure | Enhance | Good | Unsure | Enhance |
| | **Plan** | RTC | | InS CoMg | RTC | | InS CoMg |

| Doctor's Signature:<br><br>Today's Date ____________________ | Notes: | IOP @ _____<br>OD _______<br>OS _______ |
|---|---|---|

## Exam Data

| | | OD | | | OS | | |
|---|---|---|---|---|---|---|---|
| 1 Day<br>3 Day<br>10 Day<br>1 Mo<br>3 Mo<br>6 Mo<br>Other:<br>______ | **History** | Happy | Unsure | Not Happy | Happy | Unsure | Not Happy |
| | **Meds** | | | AT's ____ x a day | | | AT's ____ x a day |
| | **Acuity** | UCVA 20/ | | | UCVA 20/ | | UCVA OU 20/ |
| | **Refraction** | | | 20/ | | | 20/ |
| | | | | 20/ | | | 20/ |
| | **Cornea** | | | ○ | | | ○ |
| | **Assessment** | Good | Unsure | Enhance | Good | Unsure | Enhance |
| | **Plan** | RTC | | InS CoMg | RTC | | InS CoMg |

| Doctor's Signature:<br><br>Today's Date ____________________ | Notes: | IOP @ _____<br>OD _______<br>OS _______ |
|---|---|---|