



Sask Laser Vision

Post-Operative Assessment

DATE (MM/DD/YYYY): _____

PATIENT

Name:
DOB:
PHN:
Address:

OPTOMETRIST

Dr.
Phone:
Fax:

SURGEON

Dr. Ravikrishna Nrusimhadevara
Phone: (306) 450-0669
Fax: (306) 974-4498

RIGHT EYE

Surgery Date:

LEFT EYE

Pre-op RX:

Treatment RX:

Procedure:

RSB: Flap/Cap:

☐ 1W ☐ 1M ☐ 3M ☐ 6M ☐ 12M ☐ Other

History:

Current Drops:

Night Vision Symptoms: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Dry Eye Symptoms: ☐ None ☐ Mild ☐ Moderate ☐ Severe

UCVA OU @ D: 20/

UCVA: 20/ @ D / 20/ @N

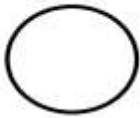
IOP: mmHg

Keratometry:

Subjective RX:

BCVA: 20/ @ D / 20/ @N

SLE:



Pre-op RX:

Treatment RX:

Procedure:

RSB: Flap/Cap:

☐ 1W ☐ 1M ☐ 3M ☐ 6M ☐ 12M ☐ Other

Night Vision Symptoms: ☐ None ☐ Mild ☐ Moderate ☐ Severe

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UCVA OU @ N: 20/

UCVA: 20/ @ D / 20/ @N

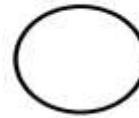
IOP: mmHg

Keratometry:

Subjective RX:

BCVA: 20/ @ D / 20/ @N

SLE:



OD Comments:

Next Visit:

Patient Satisfaction: LOW ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 HIGH

Patient Satisfaction: LOW ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 HIGH

Question to the Surgeon:

Surgeon Response:

OD INITIALS _____

MD INITIALS _____