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

Surgery Date:

RIGHT 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:

LEFT EYE

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: 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

Question to the Surgeon:

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

Surgeon Response:

OD INITIALS_____

MD INITIALS_____