RESTORATIONEYECARE
TIMOTHY McGARITY, M.D.

Refractive Surgery Post-Operative Visit

Pt. Name:			DOB:			Exam Date:	
Procedure Done:	SBK/LASIK	ASA/PRK	CK	Time Since Surgery:	1 month 12 months	3 months	6 months
						Other: _____	
Current Eye Meds:						Dominant Eye: OD	OS

VA SC:
Dist: OD: 20/_____ OS: 20/_____ **OU: 20/_____**
Near: OD: 20/_____ OS: 20/_____ **OU: 20/_____**

VA C:
Dist: OD: 20/_____ OS: 20/_____ **OU: 20/_____**
Near: OD: 20/_____ OS: 20/_____ **OU: 20/_____**

Manifest Rx:
OD _____ _____ x _____ = 20/_____
OS _____ _____ x _____ = 20/_____

K's:
OD _____ @ _____ / _____ @ _____
OS _____ @ _____ / _____ @ _____

Slit Lamp

		OD	OS
Lids:	WNL		
Conj:	WNL		
Sclerae:	WNL		
Tear Film:	WNL		
A/C:	clear and quiet		
Iris:	without rubeosis		
Lens:	clear		

Corneal Findings

Written Description: _____

Medication Instructions: _____

Follow Up Plan: _____

Discussion: _____

Doctor Name: Doctor Signature:

Please fax this completed co-management form (or equivalent) to 573-441-2288
Attn: Refractive Surgery Coordinator

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