Eye Surgeons of Indiana

LASIK Co-Management Report

Patient Name: ______________________________

Patient DOB: ______________________________

Co-managing: ______________________________

Procedure: ☐ Primary ☐ Enhancement

Target: OD __________ OS __________

OD	OS
Surgery Date: Month_____ Day_____ Year__________	Surgery Date: Month_____ Day_____ Year__________
Exam Date: Month_____ Day_____ Year__________	Exam Date: Month_____ Day_____ Year__________
Post-op Visit: ☐ 1 day ☐ 1 week ☐ 3 month	Post-op Visit: ☐ 1 day ☐ 1 week ☐ 3 month
HISTORY	
☐ Doing Well ☐ Other ______________________________	☐ Doing Well ☐ Other ______________________________
OCULAR MEDICATIONS	
☐ PMN TID ☐ ATs ☐ None	☐ PMN TID ☐ ATs ☐ None
VISION	
UCVA: 20/_____	UCVA: 20/_____
MR: ______________________________ 20/______	MR: ______________________________ 20/______
SLIT LAMP FLAP EVALUATION	
Position: ☐ excellent ☐ striae	Position: ☐ excellent ☐ striae
Clarity: ☐ clear ☐ edema	Clarity: ☐ clear ☐ edema
Interface: ☐ clear ☐ opacities ☐ ingrowth	Interface: ☐ clear ☐ opacities ☐ ingrowth
Other:	Other:
IOP (at 1 month visit): ______mmHg	IOP (at 1 month visit): ______mmHg
IMPRESSION	
☐ Excellent ☐ Other ______________________________	☐ Excellent ☐ Other ______________________________
PLAN	
☐ Continue Present Management ☐ Other	☐ Continue Present Management ☐ Other
☐ RTC ______ ☐ day(s) ☐ week(s) ☐ month(s) ☐ year	☐ RTC ______ ☐ day(s) ☐ week(s) ☐ month(s) ☐ year
☐ Refer back to Eye Surgeons of Indiana for evaluation	☐ Refer back to Eye Surgeons of Indiana for evaluation
☐ Striae ☐ Enhancement ☐ Other	☐ Striae ☐ Enhancement ☐ Other
☐ Please Call Patient ☐ Appt Made _____/_____/_________	☐ Please Call Patient ☐ Appt Made _____/_____/_________

Doctor Signature: ______________________________ Date: ______________

Please fax this form to 317.570.7433 to help us continue providing excellent results