FOCUS EYE CENTRE

POST-OPERATIVE EXAMINATION FORM (FECC)

DATE: _____ CHART # : _____

PATIENT: _____ DOB (M / D / Y): _____

HISTORY UPDATE

_____

_____

CURRENT MEDICATIONS:

_____

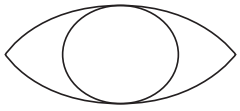
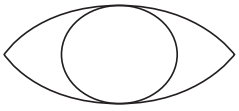
_____

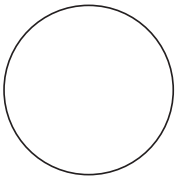
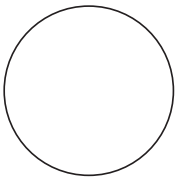
How happy are you with results? (1 – 10 where 1 is totally unhappy and 10 is totally happy) _____

SCREENING

TYPE:	OD	OU	OS
Surgery Date (M / D / Y)	/ /	/ /	/ /
Interval	☐ 1 d ☐ 1 w ☐ 1m ☐ 6m ☐ 12m ☐ Other: _____	☐ 1 d ☐ 1 w ☐ 1m ☐ 6m ☐ 12m ☐ Other: _____	☐ 1 d ☐ 1 w ☐ 1m ☐ 6m ☐ 12m ☐ Other: _____
Surgery Type	☐ SBK ☐ PRK ☐ RLE ☐ CCXL ☐ ReTx	☐ SBK ☐ PRK ☐ RLE ☐ CCXL ☐ ReTx	☐ SBK ☐ PRK ☐ RLE ☐ CCXL ☐ ReTx
Autorefraction			
AutoKeratometry			
Uncorrected va	20/	nva: _____	20/
Manifest Refraction	_____/-_____x____	ADD:+ _____	_____/-_____x____
Best Corrected va	20/	nva: _____	20/
Cyclo Refraction	_____/-_____x____ 20/		_____/-_____x____ 20/
IOP: (Tonopen)			

EXAMINATION

	OD	OS
Lids		
Iris / Pupil		
Cornea		
Interface Debris	☐ YES ☐ NO	☐ YES ☐ NO
DLK	☐ YES ☐ NO	☐ YES ☐ NO
Striae	☐ YES ☐ NO	☐ YES ☐ NO
Edema	☐ YES ☐ NO	☐ YES ☐ NO
Haze (degree)	☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ +4	☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ +4

Lens / IOL		
Retina		

COMMENTS

_____

_____

_____

RECOMMENDATION

1. ☐ OD ☐ OS ☐ OU

2. ☐ RETREAT Procedure:_____

NEXT STEP

☐ BOOK ☐ SURGEON TO EXAMINE ☐ SURGEON TO REVIEW ☐ CYCLO REFRACTION REQUIRED

☐ RTC _____

CHECKLIST

TOPIC:	YES	NO
Medication Instructions Reviewed		
Artificial Tears Discussed		
Activities / Driving / Return to Work Discussed		
Satisfaction Assessed		
Positive Feedback on Vision		
Responded to concerns		
If ReTx recommended, benefits provided		
Risks / Complications of ReTx provided		
Mitigation measures for complications		
Pt has reasonable expectations for ReTx		

SCREENING DOCTOR

SIGNATURE: _____ PRINT NAME: _____

DATE: _____