HAROLD A. STEIN, FRCSC
ALBERT CHESKES, FRCSC
RAYMOND M. STEIN, FRCSC

SEND TO:	MEDICAL DIRECTOR
FAX:	(416) 966-8917
MAIL:	40 PRINCE ARTHUR AVENUE TORONTO, ONTARIO M5R 1A9
TELEPHONE:	(416) 960-2020 • 1-800-665-1987
E-MAIL	bochner@bochner.com

Post-Procedure Assessment Report

Patient Information	Last First Mi Name: (please print)
Procedure Date	M___ / D___ / Y___ Surgeon ________________
Assessment Date	M___ / D___ / Y___ Note: Assessment required at 1 week, 1 month, 3 months, 6 months and 1 year

Post-Procedure Assessment		OD	OS
Uncorrected Visual Acuity	OU 20/	20/	20/
Manifest Refraction		20/	20/
Keratometry		Flat K @ Axis Steep K @ Axis	Flat K @ Axis Steep K @ Axis
IOP		mm Hg	mm Hg
Corneal Haze/Interace Debris Grading (Circle)		Clear Trace Mild Moderate Severe	Clear Trace Mild Moderate Severe
Ocular Medications (Following This Visit)		Med: Frequency: Med: Frequency: Med: Frequency:	Med: Frequency: Med: Frequency: Med: Frequency:

Comments/Questions	

REFERRING DOCTOR Location:	Name: (please print)	Phone: ( ) Fax: ( )
Signature:	Email:	Date: M___ / D___ / Y___