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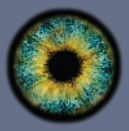

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Post-Procedure Assessment Report

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	bochnereye@bochner.com

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	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___