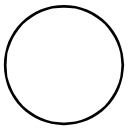
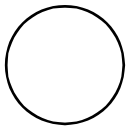
BRAVERMAN EYE CENTER LASIK/PRK POST-OP FORM

Name _____ **Date**_____ **Age**_____ **OD/MD**_____
Proced_____ **Proced. Date** OD_____ **Pre-op Rx:** OD_____ VA_____
OS_____ OS_____ VA_____
Primary / Enhancement **Aim**: OD plano / mono OS plano / mono **Meds:** PF/Fluoroquinolone QID

Va 20/ sc 20/ **Rfxn** 20/ 20/

TaG (after 1 week) @_____ TECH_____

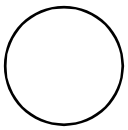
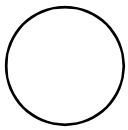
cl /spk/ % healed ___	epithelium	cl /spk/ % healed ___
well-posit /dislodged /striae	flap posit	well-posit /dislodged /striae
cl /edema /haze	clarity	cl /edema /haze
cl /opacities /ingrowth	interface	cl /opacities /ingrowth
smooth /rolled/ eroded	edges	smooth /rolled /eroded

DATE FAXED TO OD/MD _____
DATE FAXED TO BEC(954-454-5340) _____
REVIEWED BY BEC _____

Imp: Doing well/_____ **Plan:** HIG
RV: _____ days / weeks / months BEC OD/MD

Date:_____ **Meds:**

Va 20/ sc 20/ **Rfxn** 20/ 20/

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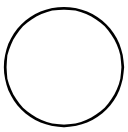
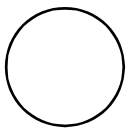

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Rev 9/09/2005