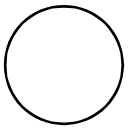
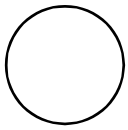
# BRAVERMAN EYE CENTER LASIK/PRK POST-OP FORM

**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

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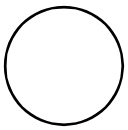
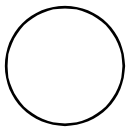
**Date:**_____ **Meds:**

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

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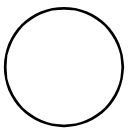
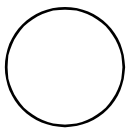
**Date:**_____ **Meds:**

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

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Rev 9/09/2005