BOSTON VISION

Please return Completed form via email or fax
Email: MyPatient@bostonvision.com
Fax: 617-860-6891

Refractive Post Operative Form

Comanaging Doctor: _____ Contact Person: _____

Patient Name: _____ Appointment Date: _____

Post Op Appointment: Week: _____ Month: _____ Other: _____

Current Medications:

☐ Moxi/Gati QID: _____ ☐ PF Q1H/QID: _____ ☐ Nevanac QID: _____

Other: _____

Complaints:

☐ NONE ☐ Halos ☐ Dryness ☐ Blurry ☐ Difficulty Driving ☐ Difficulty Reading_____

VA (Unaided)

OD 20/ PH 20/

OS 20/ PH 20/

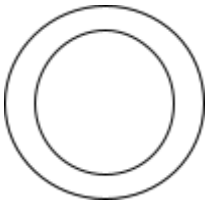
MRX

OD _____ 20/

OS _____ 20/

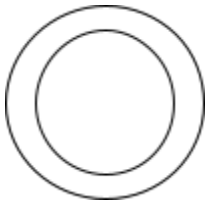
SLE:

OD:



☐ SPK ☐
☐ Wrinkles ☐
☐ Epi Defect ☐
☐ Haze ☐
☐ Epi Cell ☐
☐ Debris ☐
☐ DLK ☐

OS:



Impression:

OD	S/P ☐LASIK ☐PRK /_____ Condition: _____
OS	S/P ☐LASIK ☐PRK /_____ Condition: _____

Plan:

			DC
☐ PF QID x _____/taper	☐ OD	☐ OS	☐
☐ Vigamox QIDx_____days	☐ OD	☐ OS	☐
☐ Nevanac QIDx_____days	☐ OD	☐ OS	☐
☐ Tears minimum QID	☐ OD	☐ OS	☐
☐ Genteal ung QHS	☐ OD	☐ OS	☐
☐ Other: _____			☐

Comments: _____

Enhancement Recommended ☐

Follow up: _____D/W/M w/ Dr. _____ &_____D/W/N w/ Boston Laser, Time _____