SightLine Laser Eye Center

LASER VISION CORRECTION FOLLOW-UP

Please fax this form to 724-933-6051.

PATIENT NAME _____ REFERRING DOCTOR _____

DATE OF BIRTH _____ PROCEDURE DATE(S) _____

DATE OF EXAM _____ ☐ 1 WEEK ☐ 1 MONTH ☐ 3 MONTH ☐ OTHER
(REQUIRED)

TREATMENT: ☐ Primary ☐ Enhancement

UNCORRECTED VA OD: 20 / _____

OS: 20 / _____

REFRACTION OD: _____ VA 20 / _____

OS: _____ VA 20 / _____

HAVE THERE BEEN ANY COMPLICATIONS OR UNANTICIPATED EVENTS? OD: ☐ NO ☐ YES
If yes, explain and describe treatment. OS: ☐ NO ☐ YES

IS THE PATIENT EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

If yes, please explain.	OD:	OS:
Ocular surface irritation?	☐ NO ☐ YES	☐ NO ☐ YES
Night time glare?	☐ NO ☐ YES	☐ NO ☐ YES
Shadowy or Blurred images?	☐ NO ☐ YES	☐ NO ☐ YES

HOW WOULD YOU RATE THE PATIENT'S SATISFACTION WITH LVC?

OD: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

OS: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

ADDITIONAL COMMENTS:

_____ Report Faxed to SightLine Signature _____