ADELAIDE eye&laser CENTRE

REFRACTIVE POST OPERATIVE DATA FORM

Assessment Date: / /

PATIENT DETAILS

Name: ..... DOB: .....

Address: .....

Suburb: ..... State: ..... Postcode: ..... Telephone: .....

PATIENT HISTORY / SYMPTOMS

EXAMINATION DATA

	RIGHT EYE		LEFT EYE	
VAsc / VAcc				
Refraction				
Keratometry K1				
Keratometry K2				
Corneal Haze				
IOP				
Other findings				

General comments

PRACTITIONER DETAILS

Date: *Signed:*

Please post or fax to Adelaide Eye & Laser Centre, 215 Greenhill Road, EASTWOOD SA 5063 Ph: 8274 7000 Fax: 8274 7099