



**LASIK FOLLOW UP DETAILS:**

**Date:**

Follow up record of Ms / Mr :  
MRD No :  
Your Lasik Surgeon @ Nethralaya : Dr.  
Date of LASIK Procedure @ SN :  
Follow up date : ...../...../..... [Months(s) follow up]

**Unaided Visual Acuity:**

Right Eye: \_\_\_\_\_

Left Eye: \_\_\_\_\_

**Refraction:**

Right Eye: \_\_\_\_\_ Visual Acuity \_\_\_\_\_

Left Eye: \_\_\_\_\_ Visual Acuity \_\_\_\_\_

**Corneal Status:**

Right Eye: \_\_\_\_\_

Left Eye: \_\_\_\_\_

**Intra Ocular Pressure (IOP):**

Right Eye: \_\_\_\_\_

Left Eye: \_\_\_\_\_

**Signature of Ophthalmic Consultant**

**Date:**

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Kindly send the above details to:

**LASIK Dept  
Sankara Nethralaya (JKCN Complex)  
21, Pycrofts Garden Road, Chennai – 600 006  
Fax No: 91 –044 – 28254180, E Mail: [lasik@snmail.org](mailto:lasik@snmail.org)**

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**Appointment for LASIK Services: 0 93801 07258 / 0 93802 88188**

