

[Clinic Name]  
[Clinic Address]  
[Phone Number]  
[Date]

To: [Patient Name]  
[Patient Address]

**Subject: Follow-Up Instructions After Laser Photocoagulation Therapy**

Dear [Patient Name],

This letter is to follow up on your recent laser photocoagulation procedure performed on [Date of Procedure]. This treatment was conducted to stabilize your retinal condition and prevent further vision loss.

**Post-Treatment Care:**

- It is normal to experience blurred vision or a dull ache for 24 to 48 hours.
- You may see small spots or "floaters" in your vision temporarily.
- Wear sunglasses if your eyes are sensitive to light.
- Continue using any prescribed eye drops as instructed by your doctor.

**Urgent Symptoms:**

Please contact our office immediately if you experience any of the following:

- Sudden, severe eye pain.
- A significant, sudden decrease in vision.
- Flashing lights or a shadow/curtain moving across your field of vision.
- Excessive redness or swelling.

**Scheduled Follow-Up Appointment:**

Date: [Appointment Date]

Time: [Appointment Time]

Location: [Office/Clinic Location]

If you have any questions before your next visit, please call us at [Phone Number].

Sincerely,

[Doctor's Name]  
[Practice Name]