SMILE Procedure Discharge Summary

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Surgeon: [Insert Surgeon Name]

This letter confirms that the patient underwent a SMILE (Small Incision Lenticule Extraction) procedure on [Insert Date] for the correction of [Myopia/Astigmatism]. The procedure was completed successfully without complications.

Procedure Details

Eye(s) Treated: [Left / Right / Both]

Post-Operative Vision: [Insert Immediate Post-Op Visual Acuity]

Post-Operative Medication Schedule

- **Antibiotic Drops:** [Insert Name] - [Frequency] for [Duration]
- **Steroid Drops:** [Insert Name] - [Frequency] for [Duration]
- **Lubricating Drops:** [Insert Name] - Use as needed for dryness.

Important Instructions

- Do not rub your eyes for at least one week.
- Avoid getting tap water, soap, or shampoo in your eyes for 3 days.
- Wear eye shields while sleeping as instructed.
- Avoid swimming and contact sports for 2 weeks.
- Use UV-protective sunglasses when outdoors.

Follow-Up Appointments

1-Day Post-Op: [Date/Time]

1-Week Post-Op: [Date/Time]

1-Month Post-Op: [Date/Time]

When to Contact the Clinic Immediately

Contact us at [Insert Phone Number] if you experience:

- Sudden or severe eye pain.
- Significant decrease in vision.
- Increased redness or unusual discharge.
- Flashing lights or a sudden increase in floaters.

Signed,

[Doctor Signature]

[Clinic Name]