Clinic Name: [Insert Clinic Name]

Address: [Insert Clinic Address]

Phone: [Insert Phone Number]

Date: [Insert Date]

PATIENT DETAILS:

Name: [Patient Full Name]

Date of Birth: [DD/MM/YYYY]

Patient ID: [Insert ID Number]

PROCEDURE SUMMARY:

Date of Procedure: [Insert Date]

Procedure Type: [e.g., LASIK / PRK / SMILE]

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

Surgeon: [Insert Surgeon Name]

DISCHARGE STATUS:

The patient has successfully undergone outpatient laser eye surgery. The procedure was completed without complications. The patient is stable and fit for discharge to the care of a responsible adult.

POST-OPERATIVE MEDICATIONS:

- Antibiotic Drops: [Name/Frequency/Duration]
- Anti-inflammatory Drops: [Name/Frequency/Duration]
- Lubricating Drops: [As needed/Frequency]

RECOVERY INSTRUCTIONS:

- Wear the provided eye shields while sleeping for [Number] nights.
- Do not rub or touch the eyes.
- Avoid swimming, hot tubs, and dusty environments for [Number] weeks.
- Avoid heavy lifting or strenuous exercise for [Number] days.

- Use UV-protective sunglasses when outdoors.

FOLLOW-UP APPOINTMENT:

Date: [Insert Date]

Time: [Insert Time]

Location: [Insert Location]

EMERGENCY CONTACT:

Please contact us immediately at [Insert Emergency Number] if you experience: sudden loss of vision, severe pain that does not respond to medication, or a sudden increase in redness/discharge.

Signed: _____

[Doctor Name/Title]