

**Date:** [Date]

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Patient ID:** [ID Number]

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# Discharge Summary: Vision Correction Surgery

**Procedure Performed:** [LASIK / PRK / SMILE / ICL]

**Date of Procedure:** [Date]

**Surgeon:** [Surgeon Name]

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

## 1. Post-Operative Medications

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

## 2. Immediate Care Instructions

- Wear eye shields while sleeping for the next [Number] nights.
- Do not rub or press on your eyes.
- Avoid getting water, soap, or sweat in your eyes for [Number] days.
- Wear sunglasses when outdoors to protect against UV and debris.

## 3. Activity Restrictions

- **Driving:** Do not drive until cleared by your doctor.
- **Exercise:** Avoid strenuous activity or contact sports for [Number] weeks.
- **Makeup:** Do not wear eye makeup for [Number] days.
- **Swimming:** Avoid pools, hot tubs, and lakes for [Number] weeks.

## 4. Warning Signs

Please contact the clinic immediately if you experience:

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

## **5. Follow-Up Appointments**

- **1-Day Check:** [Date and Time]
- **1-Week Check:** [Date and Time]
- **1-Month Check:** [Date and Time]

**Emergency Contact:** [Phone Number]

**Clinic Address:** [Address]

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Medical Professional Signature