Date: [Date]

DISCHARGE SUMMARY

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID: [ID Number]

Procedure: [Procedure Type, e.g., LASIK / PRK / Toric ICL]
Date of Procedure: [Date]
Surgeon: [Surgeon Name]

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1. Clinical Outcome

The patient underwent successful surgical correction for astigmatism in the [Left / Right / Both] eye(s). The immediate post-operative examination shows stable flap/incision integrity and satisfactory initial visual acuity.

2. Post-Operative Medications

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

3. Activity Restrictions and Care

- Do not rub or touch the eyes.
- Wear the provided eye shields while sleeping for [Number] nights.
- Avoid getting tap water, soap, or sweat in the eyes for [Number] days.
- Avoid swimming and contact sports for [Number] weeks.
- Wear UV-protection sunglasses when outdoors.

4. Follow-Up Schedule

The patient is scheduled for the following mandatory check-ups:

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

5. Emergency Contact

Seek immediate medical attention if you experience: Sudden loss of vision, increasing pain, excessive discharge, or new flashes/floaters.

Emergency Line: [Phone Number]

Authorized Signature: ___________________________

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