

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

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

1. PROCEDURE SUMMARY

The patient underwent uncomplicated vision correction surgery on [Insert Date]. The procedure was performed on the [Left / Right / Both] eye(s). The patient is being discharged in stable condition.

2. IMMEDIATE POST-OPERATIVE INSTRUCTIONS

- **Rest:** Go home and rest with your eyes closed for at least 4 to 6 hours.
- **Eye Protection:** Wear the provided clear plastic shields or sunglasses at all times today and while sleeping for the next [Insert Number] nights.
- **Do Not Rub:** Under no circumstances should you rub or touch your eyes.

3. MEDICATIONS AND EYE DROPS

Please follow the schedule below for your prescribed eye drops:

- **Antibiotic Drops:** [Insert Name] - [Insert Frequency] for [Insert Duration].
- **Anti-inflammatory Drops:** [Insert Name] - [Insert Frequency] for [Insert Duration].
- **Lubricating/Tear Drops:** Use every [Insert Frequency] or as needed for dryness.

4. ACTIVITY RESTRICTIONS

- Avoid getting water, soap, or sweat in your eyes for [Insert Number] days.
- No eye makeup for [Insert Number] week(s).
- Avoid swimming and hot tubs for [Insert Number] weeks.
- Avoid dusty environments and contact sports for [Insert Number] weeks.

5. FOLLOW-UP APPOINTMENT

Your follow-up exam is scheduled for:

Date: [Insert Date] at **Time:** [Insert Time]

Location: [Insert Clinic Address]

6. WHEN TO CALL THE CLINIC

Contact us immediately if you experience:

- Sudden, severe pain that is not relieved by over-the-counter medication.
- A sudden decrease or loss of vision.
- Increased redness or thick discharge from the eye.
- Flashing lights or a sudden increase in floaters.

Emergency Contact Number: [Insert Phone Number]

Physician Signature: _____

Clinic Name: [Insert Clinic Name]