

FIRST NAMES (Block Letters)

NIIAMOAH

FIRST NAMES

FOSUHENE

Sex

MALE

PHONE NUMBER..... 0264888346

ADDRESS OR RESIDENTIAL..... PLOT 7 Block 8 Ashanti region Kumasi
- Adabraka

OCCUPATION

Movie Director

MARITAL STATUS

MARRIED	DIVORCED	SINGLE	OTHER
		✓	

DATE OF BIRTH

06/1993

AGE
23

PLACE OF BIRTH

Asanti Mampong

ANY ALLEGIC REACTION
TO MEDICINE

NATIONALITY

Ghanian

RELIGION

Christian

DATE OF FIRST ATTENDANCE

9th September 2016

NEXT OF KIN

DIA NIIAMOAH

ADDRESS OR PHONE NO. OF NEXT OF KIN

024105 3378

ky - Gaf3o. fad \$ 14/17

P/L WORK : 5000
per day



INTER-STAR EYE CLINIC & LASER CENTRE

NAME: Mr. Fosohene Ntiamoh

CARD NUMBER: 13371

DATE: 9/07/2016

c/c Blurred vision in BB for 8 yrs, squint in
BB.
Asthma ϕ , SCD ϕ .

VR 6/60⁻, 6/24⁻ PH VE 6/36⁻, 6/18⁻ PH

Exophoria

A
17 17

- ✓ HD ✓
- ✓ conjunctiva ✓
- ✓ cornea ✓
- ✓ lens ✓
- ✓ fundi ✓

plan: Cornea topography

Dr. Brauer

5-4-17 % Review.

VR 6/60cm, 6/9gl

VR 6/36cm, 6/9gl

CCT 574
584

	R
K ₁	39
K ₂	43

B1 Guy pen - N/A

WAD - fully - WAD

Pla

① RL LASIK

Su B

5/20/17 RL fents - LASIK

done

pla

① Vigant w/

② Pres faste
2nd
3rd

③ Nevance 2nd

④ fbs Ponstan B
(w) brd



INTER-STAR EYE CLINIC & LASER CENTRE

NAME:

CARD NUMBER:

DATE:

9/4 Review

VR Glizua, 8/9-#pt

z Glizua, 8/9-#pt

Auto -6.25/-9.00 X 9.
error

R/L - far clear close - far clear

error	36.25	- far	close	close
	38.25	- SW	Tent	
	132	want	close	

want - the - good

IOP
12 "

plus
O J

O T. software Free

6X
BU

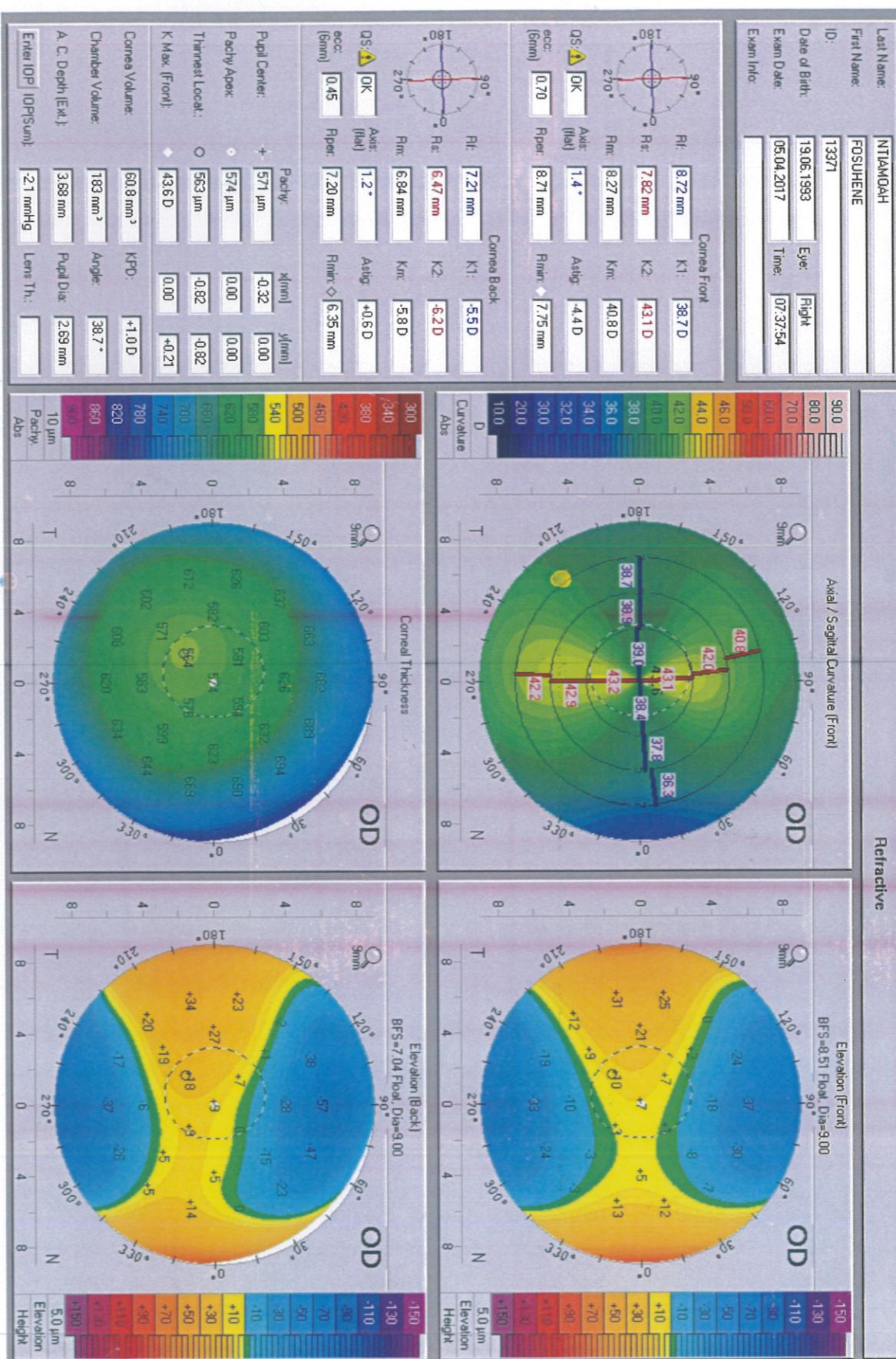
Sun 8/7



Wavelight

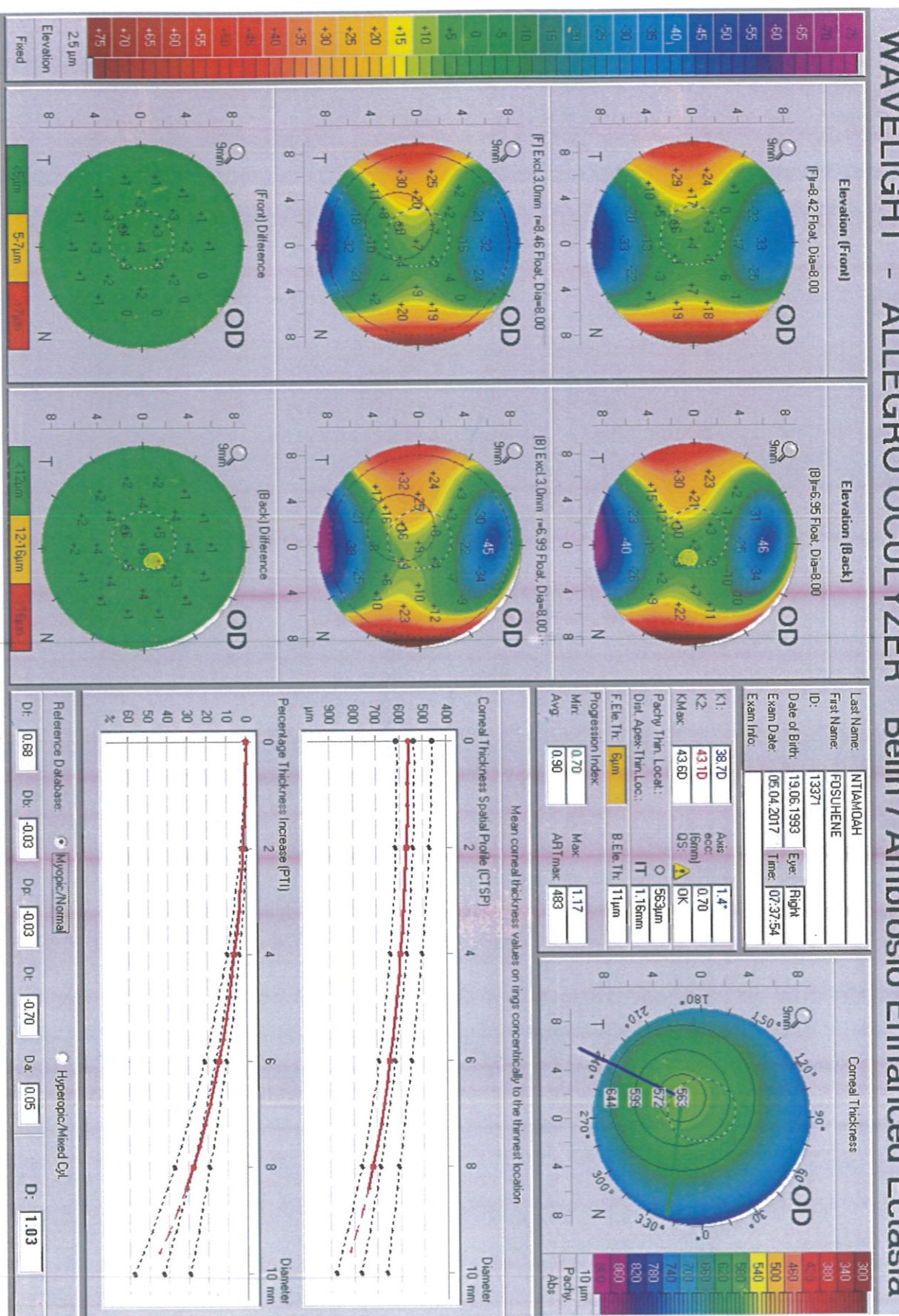
®

WAVELIGHT - ALLEGRO OCULYZER 4 Maps Refractive



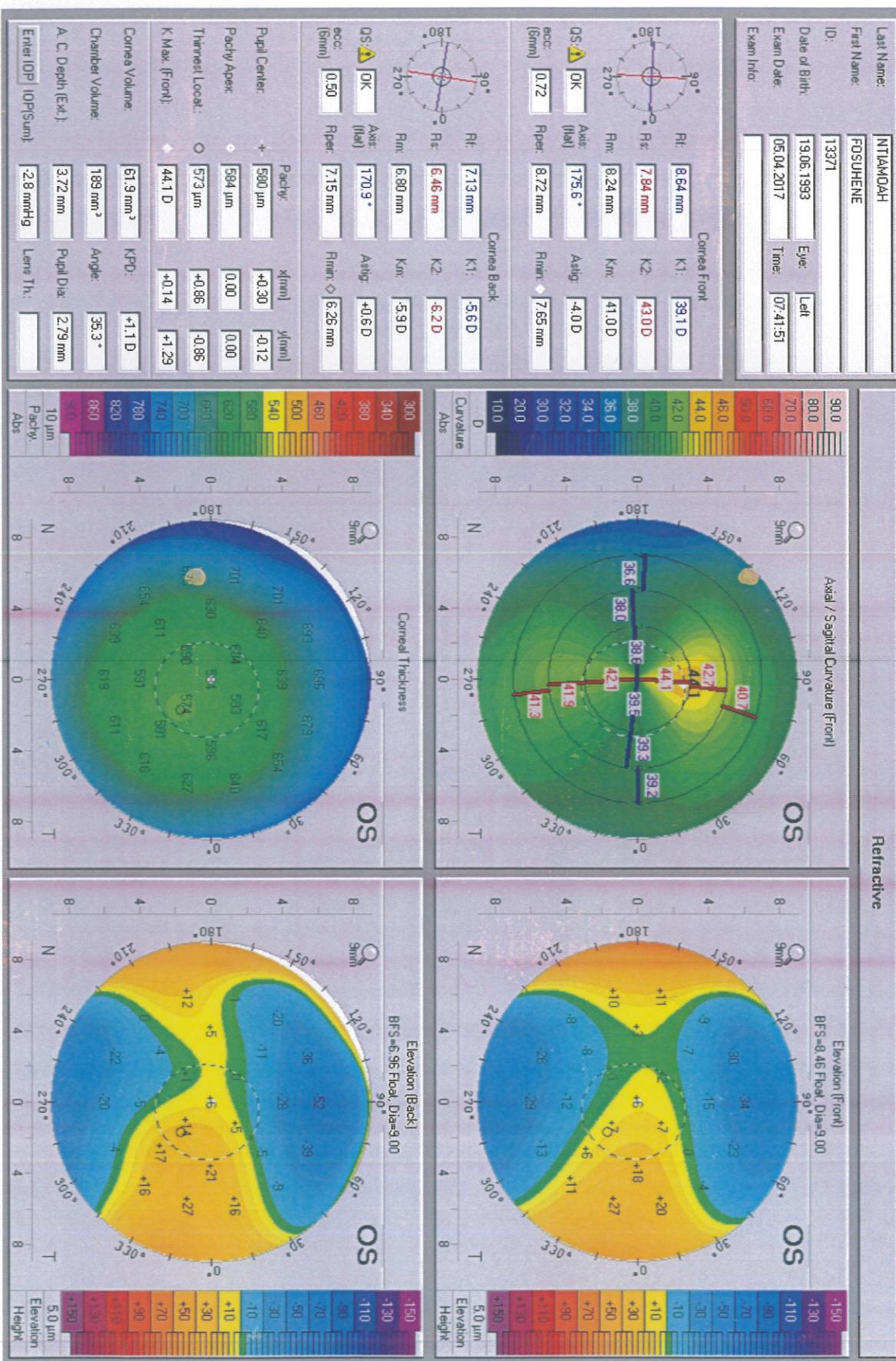
Wavelight®

WAVELIGHT - ALLEGRO OCULYZER Belin / Ambrósio Enhanced Ectasia



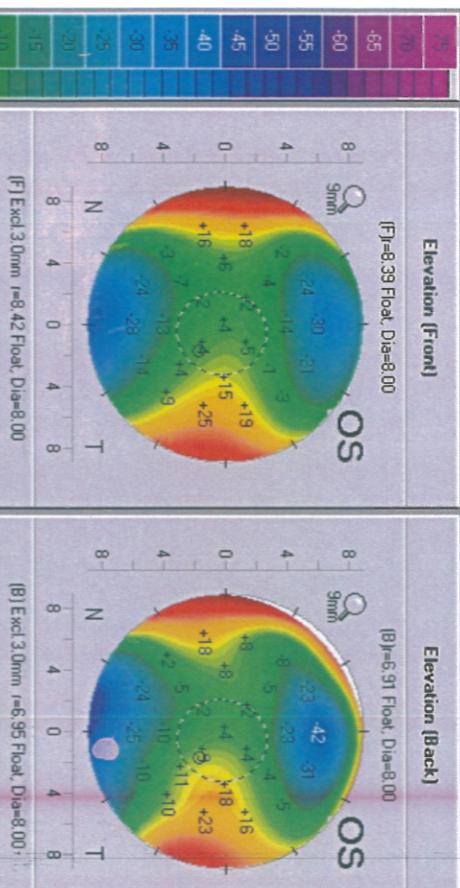


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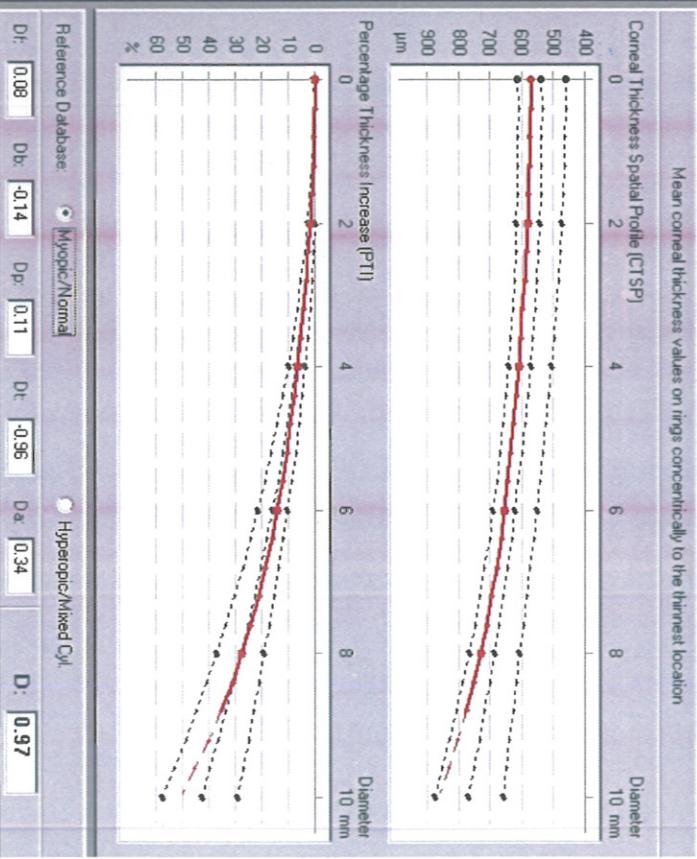
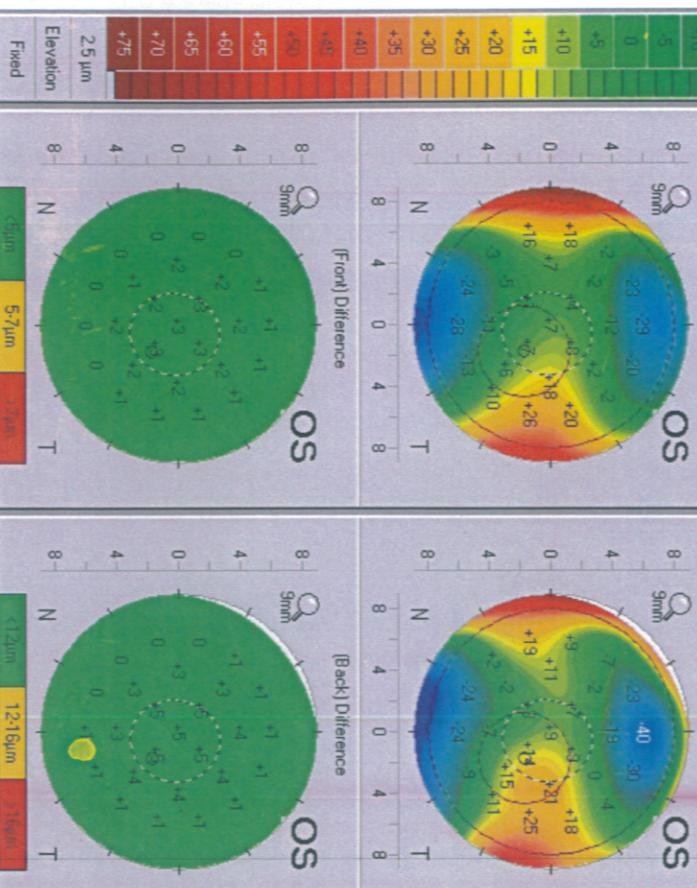
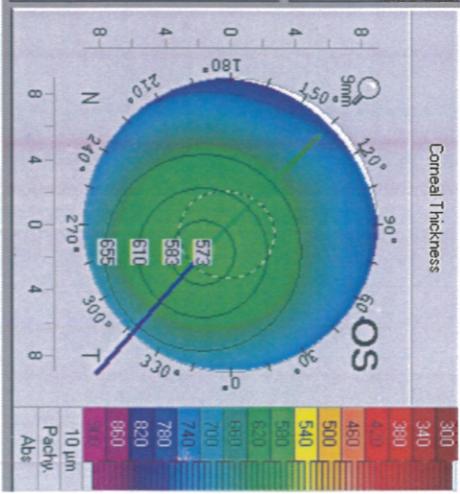




WAVELIGHT - ALLEGRO OCULYZER Belin / Ambrósio Enhanced Ectasia



Last Name:	NTIAMDAH		
First Name:	FOSUHENE		
ID:	13371		
Date of Birth:	19.06.1993		
Exam Date:	05.04.2017		
Exam Info:	Axis: 175.6° ect: 0.72 KSm: 0.5m  OK		





INTER STAR EYE CLINIC AND LASER CENTRE

NAME SURNAME : NTI AMOATA K. OFOSUHENE		DATE : 5/4/17	PROTOCOL NUMBER :	
DATE OF BIRTH : 19/06/1993		PROFESSION : MOVIE DIRECTOR		
ADDRESS :		TEL : 0264888346		
TREATMENT METHOD	RIGHT EYE			LEFT EYE
	LASIK	FS	PRK	LASEK
	RING	WAVEFRONT	OK	RING
VISION	UNAID	8160		8136
	AIDED	819		619
GLASSES/CONTACT LENS		-6.00/-2.00 X180		
AUTOREFRACTOMETER		-13.00/-6.25 X178		
WAVEFRONT				
CYCLOPLEGIC AUTO				
ANTERIOR SEGMENT		Normal		
POSTERIOR SEGMENT		N/A		
INTRA OCULAR PRESSURE (IOP)		17		
PACHYMETRY		570 um		
PUPIL DIAMETER		2.6mm		
CORRECTION		-4.75/-1.50 X180		
NOTE :				
SURGEON :				



INTER-STAR EYE CLINIC & LASER CENTRE

CONSENT FORM

NAME..... Kwame Ntiamoah
SEX..... male
D. O. B..... 19th June 1993
ID NO.....

OPERATION CONSENT BY PATIENT/RELATIVE

I..... Augustin Bonu
On behalf of..... Kwame Ntiamoah
Hereby consent to undergo the operation of..... LASIK (R/L)

The effect and nature of which has been explained to me

I also consent to such further or alternative measures as may be found to be necessary during the course of such operation and the administration of local or other anesthetic for the purpose of same

I understand an assurance has not been given that the operation will be performed by a particular surgeon

Signature of patient/relative.....

Date 5th April 2017

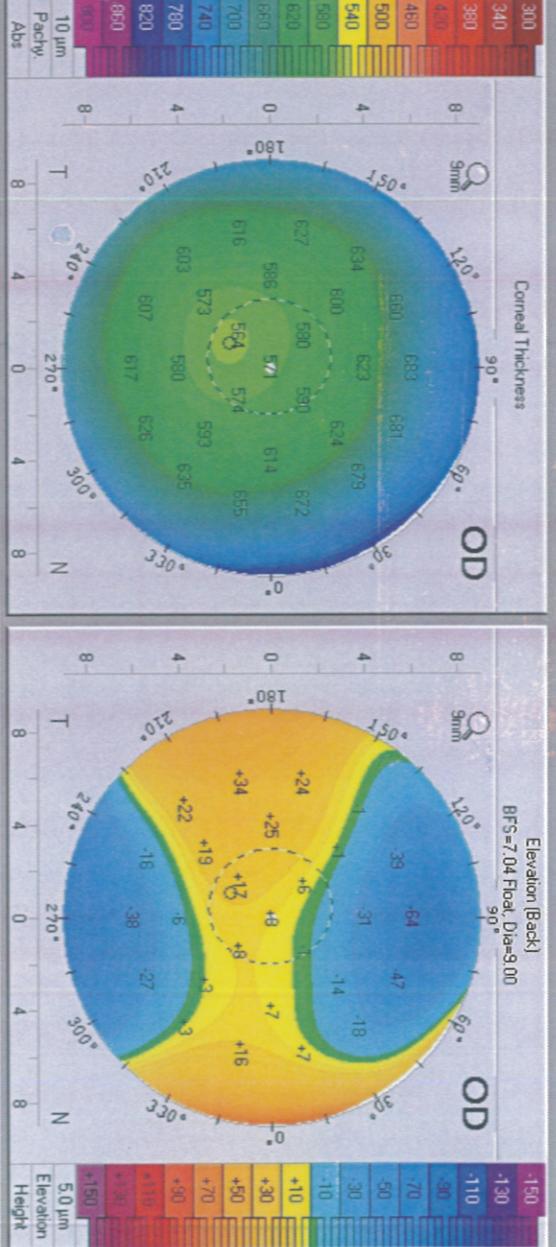
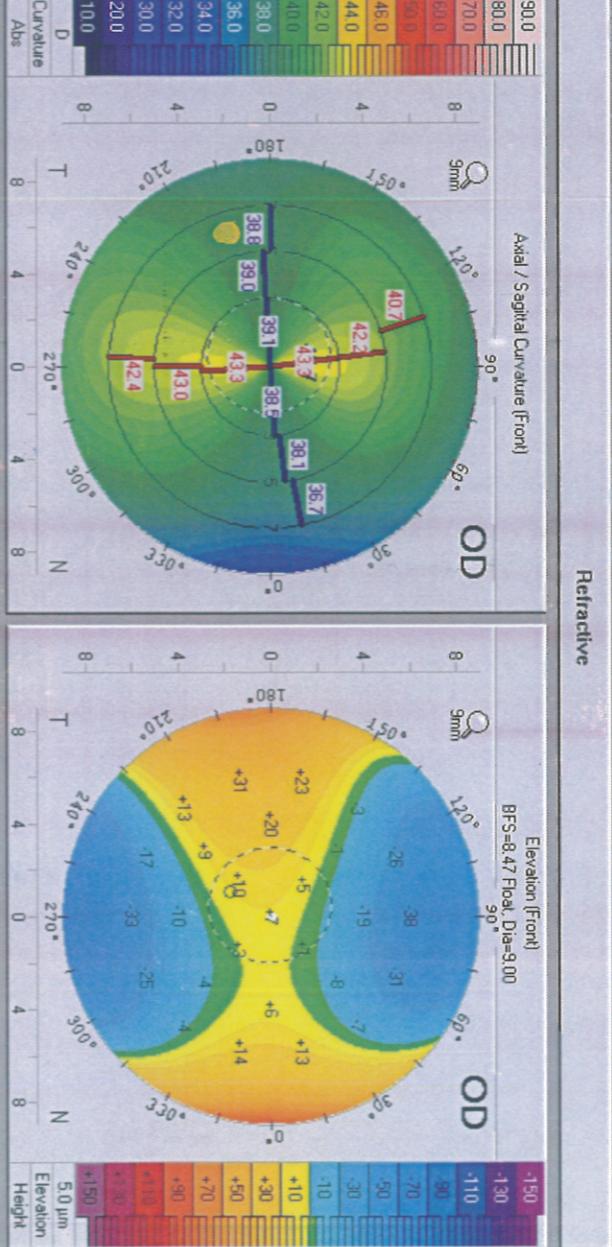
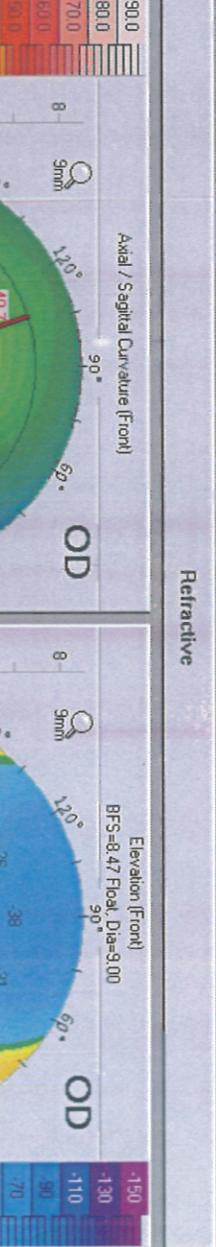
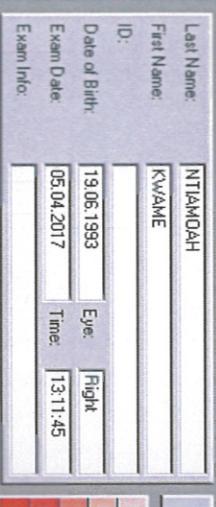
I have seen this consent before surgery and explained the nature of the operation to patient/relative

Signature of Doctor.....

Date

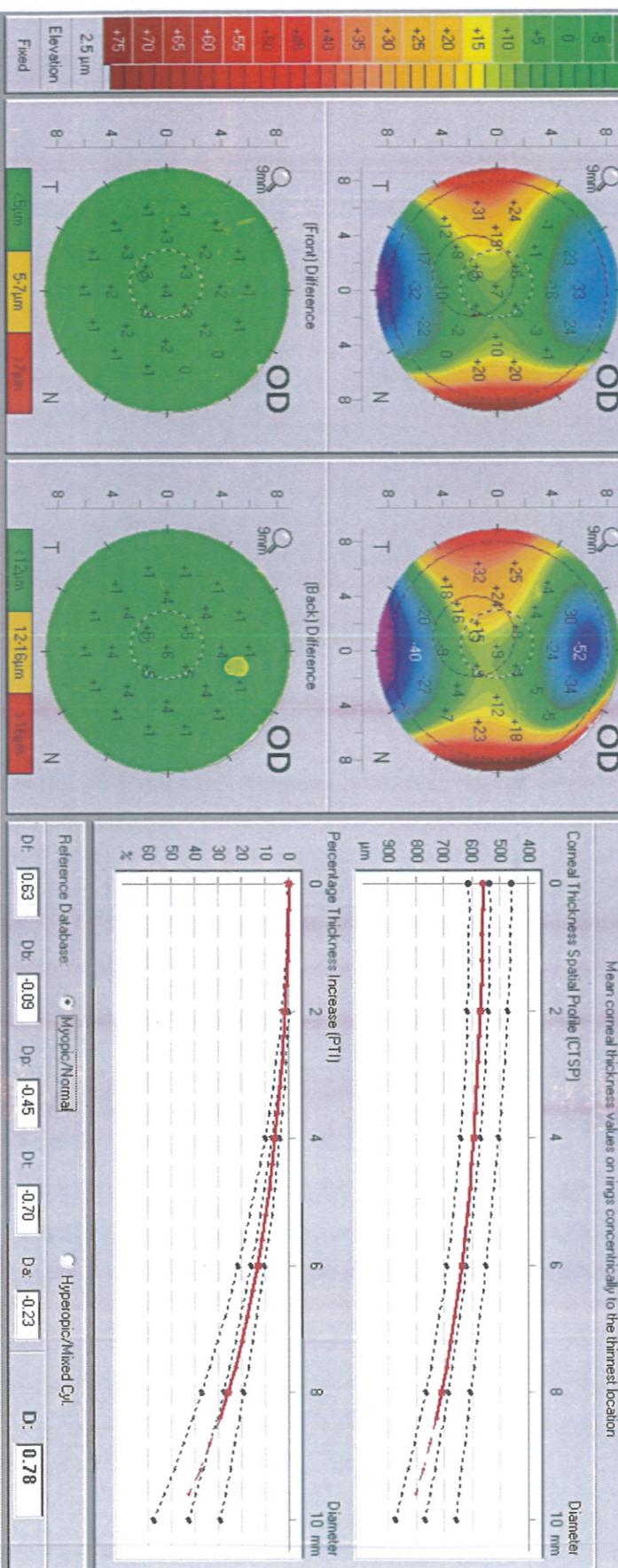
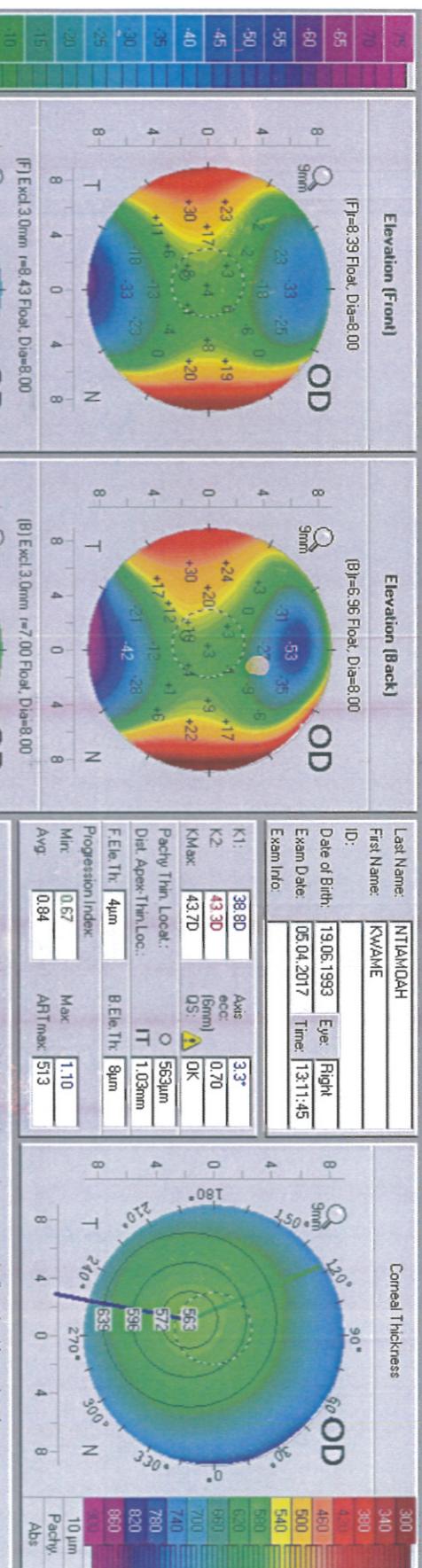


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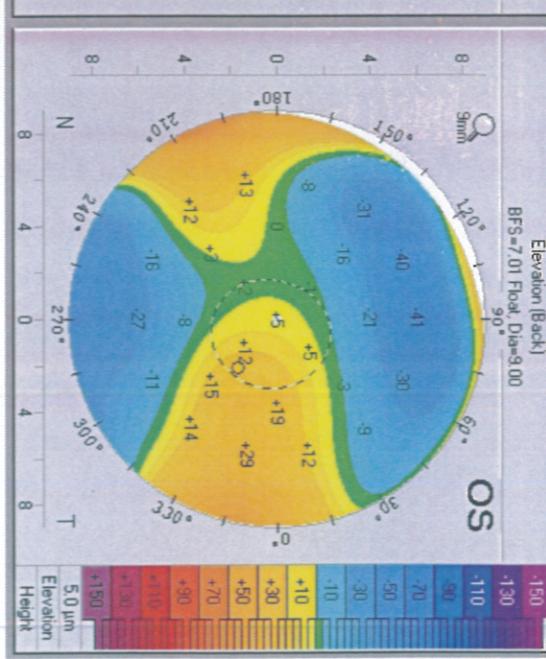
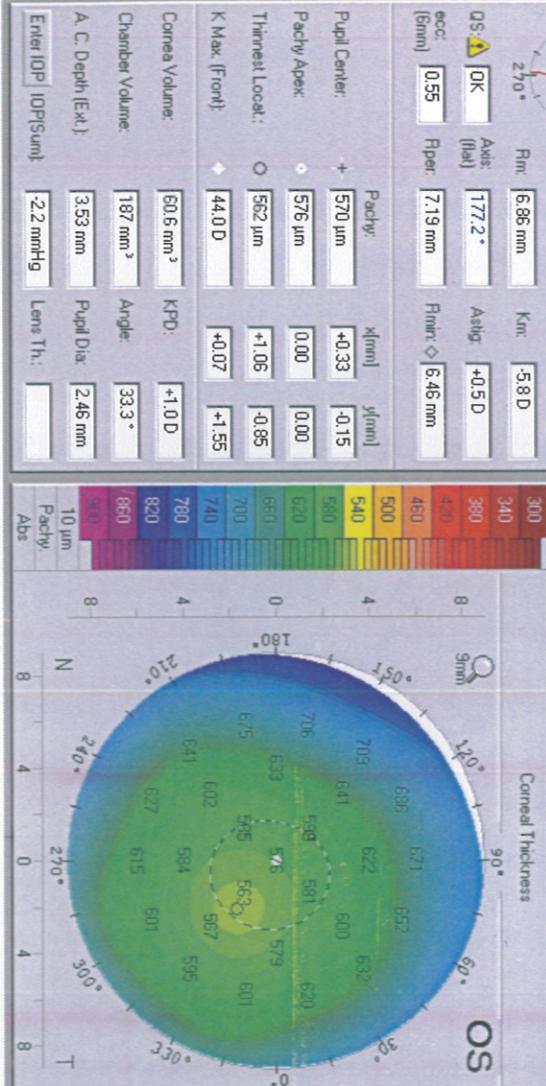
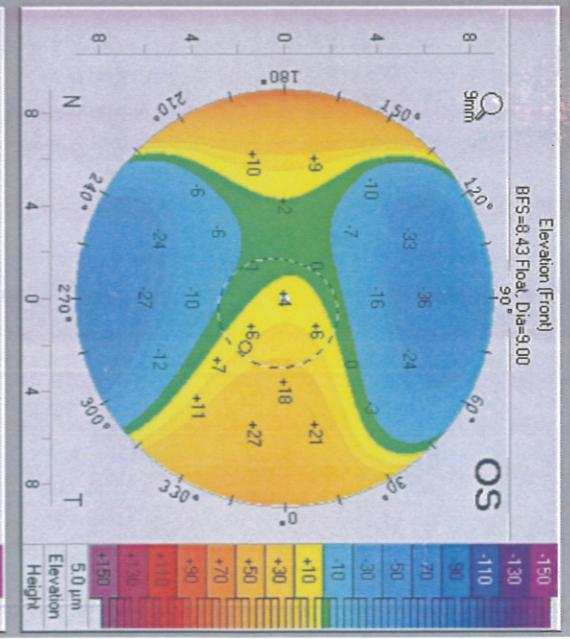
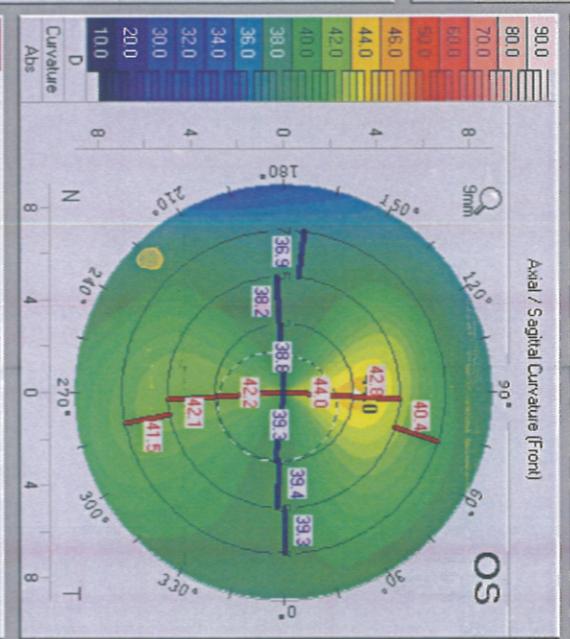
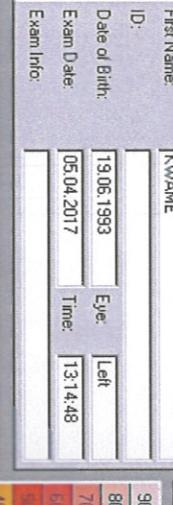
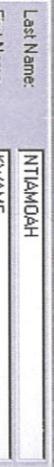


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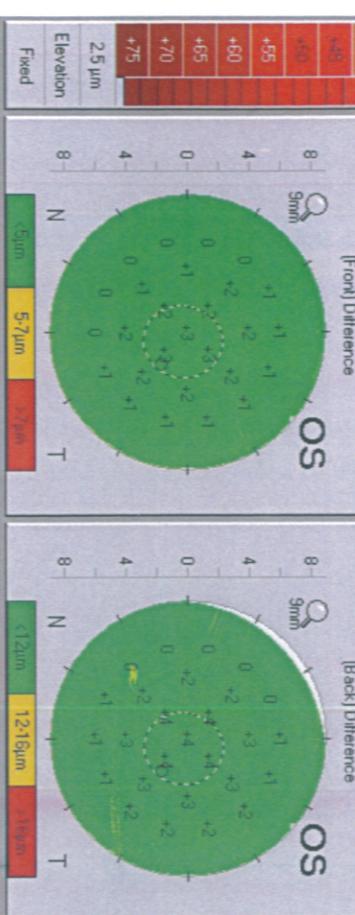
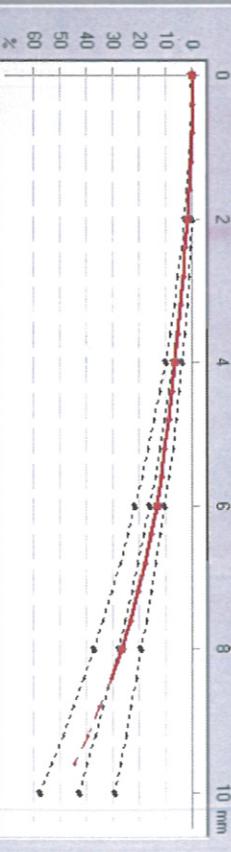
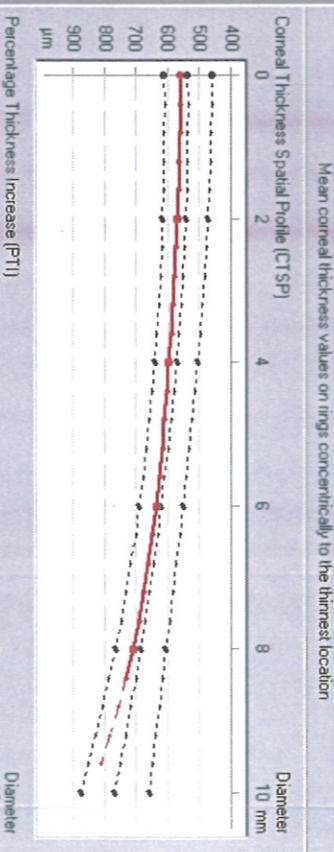
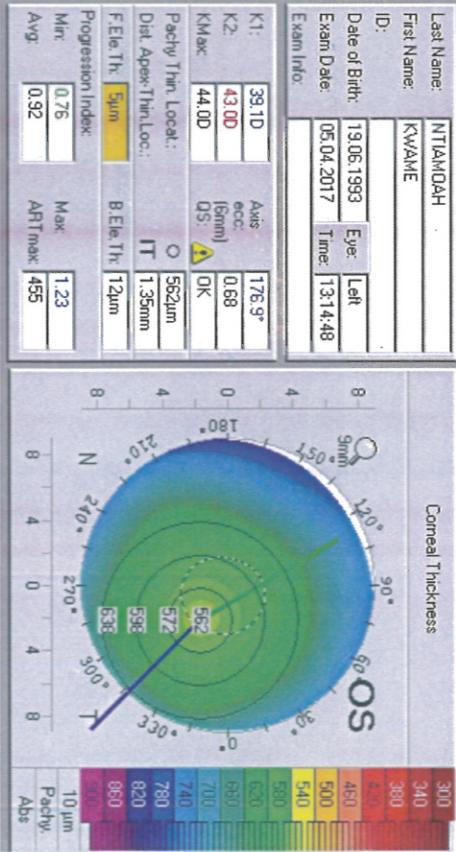
WAVELIGHT - ALLEGRO OCULYZER 4 Maps Refractive



A graphic element consisting of three thick, blue, wavy horizontal lines arranged vertically.

WAVELIGHT - ALLEGRO OCULYZER

Belin / Ambrósio Enhanced Ectasia



20

80

Me

13371



INTER-STAR EYE CLINIC & LASER CENTER

Loc: 10th Lane H/No. F764/1 Osu, RE Accra, Old American Embassy Road, Opposite
Buka Restaurant Near Citizen Kofi. E-mail: Interstareyeclinic@gmail.com Tel: 0302-783832 / 027-7755354

NAME: _____	TEL HOUSE _____	WORK _____						
ADDRESS: _____								
DATE OF TEST <i>9-9-16</i>	R PRESCRIPTION GIVEN							
	Dist	Sph	Cyi	Axis	Prism	Sph	Cyi	Axis
P.D. <i>69mm</i>	<i>-6.00 -2.00</i>	<i>180</i>		<i>+4.00</i>				
HEIGHTS R L	MONO R L		BLANK			TECH SIG. CHECKED		
DISPENSING NOTES		DESCRIPTION					GH¢	P
		FRAME						
		LENSES						
		COATING						
		SUNDRIES						
					TOTAL			
					VOUCHER			
					BALANCE			
					DEPOSIT			
					BALANCE			
PLEASE TICK	<input type="checkbox"/> CASH		<input type="checkbox"/> CHEQUE		<input type="checkbox"/> CREDIT CARD			
DISPENSED BY	CHECKED BY		RECEIVED BY			DATE		

SYMPTOMS & HISTORY	<u>balanced</u>	OCCUPATION Hobbies
EXTERNAL EXAMINATION OPHTHALMOSCOPY	R - 6.00 / -2.00 X 180 L - 4.00 DS	FIELD TONOMETRY COLOUR ETC.
OPHTHALMOSCOPY	SUBJECTIVE 6/60 NLP 6/36 NLP	ACCOMMODATION R = 6/9 L = 6/12 Rdg ADD) 6/9 Binoc ADD) = N
MUSCLE BALANCE	<u>Auto</u>	RETEST DATE
	R - 13.00 / -6.25 X 178 L - 10.25 / -5.25 X 178	