CLARITY
LASER VISION

POST-PROCEDURAL
FORM

Please fill out the infromation below & Fax this form to 403.640.0456

Referring Doctor: _____ **Patient name:** _____

Phone: _____ _____ – _____ **Date of birth:** _____

Date of examination: _____ **Phone:** (HOME) _____ (WORK) _____

E-mail: _____

Post-Op Exam:

OD	☐ 2 WEEKS	☐ 1 MONTH	☐ 3 MONTH	☐ 6 MONTH	☐ OTHER
OS	☐ 2 WEEKS	☐ 1 MONTH	☐ 3 MONTH	☐ 6 MONTH	☐ OTHER

Post-Op Medication (Names): _____

Comments/Chief Complaint: _____

OD			OS
20/_____ J _____	UNCORRECTED VISION		20/_____ J _____
_____ 20/_____	MANIFEST REFRACTION		_____ 20/_____
_____	K's		_____
_____ mmHg	IOP's		_____ mmHg
_____	SLIT LAMP EXAM		_____
_____	FUNDUS		_____

Advice to Patient: _____

Recommendation/Plan: _____