

POST-PROCEDURAL FORM

Please fill out the information 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

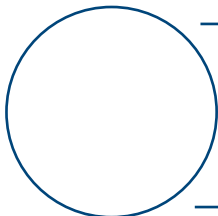
Post-Op Medication (Names): _____
 Comments/Chief Complaint: _____

OD

OS

20/_____ J _____ UNCORRECTED VISION 20/_____ J _____

20/_____ MANIFEST REFRACTION _____ 20/_____



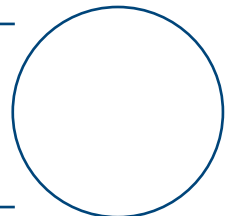
K's _____

mmHg

IOP's _____ mmHg

SLIT LAMP EXAM _____

FUNDUS _____



Advice to Patient: _____

Recommendation/Plan: _____