Please FAX this form to PACIFIC VISION INSTITUTE
(415) 922-9568
Attn: Comanagement Department

POST-OPERATIVE Evaluation Form

Referring Doctor: _____ Follow-up Exam Date: _____

Patient's Name: _____ Procedure Date: OD _____OS_____

Post-Operative Exam

OD: _____1 week _____1 month _____3 months _____6months _____other

OS: _____1 week _____1 month _____3 months _____6months _____other

Post-Operative Meds:_____

Patient Comments

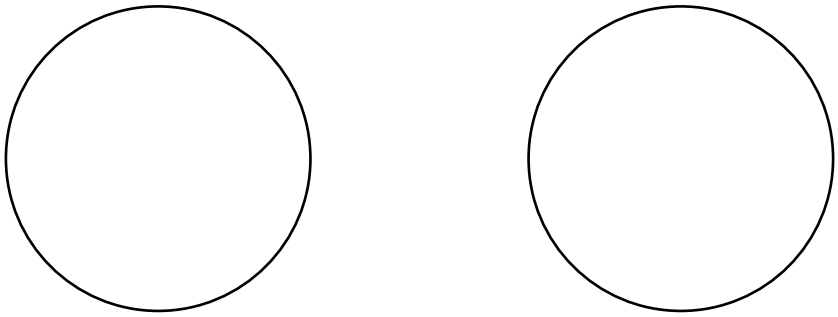
_____

_____

Exam:	**OD**	**OS**
VA SC (lights on)	20/_____J_____	20/_____J_____
MR (dim lights)	_____20/_____	_____20/_____
CR (dim lights)	_____20/_____	_____20/_____

(only if enhancement is indicated)

Slit Lamp:



Advice to Patient: _____

Questions to Surgeon: _____

_____
(Co-managing Doctor's Signature)

Date:_____

Notes to Co-managing Doctor: _____

_____

_____

Enhancement: _____Yes _____No _____
Surgeon's Sinature