

P (416) 929-2020
F (416) 929-0232

POST-OPERATIVE FORM

- Dr. Herzig
- Dr. Taylor
- Dr. Ma
- Dr. Eplett
- Dr. Choudhry

Date of Examination: _____ (DD/MM/YYYY)

Date of Birth: _____ (DD/MM/YYYY)

Patient Name: _____

Date of Surgery: _____ (DD/MM/YYYY)

OD

Cataract

1 month

Other _____

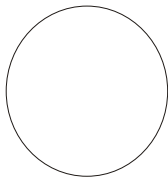
UCVA

IOP

20/ _____

M _____ X _____ 20/
C _____

Slit Lamp Exam



Medication: _____

Comments: _____

OS

Cataract

1 month

Other _____

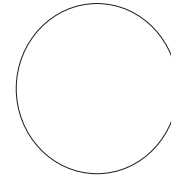
UCVA

IOP

20/ _____

M _____ X _____ 20/
C _____

Slit Lamp Exam



Medication: _____

Comments: _____

Referring Physician: _____

Address: _____

Phone #: _____ Fax #: _____

Email: _____