HERZIG
EYE INSTITUTE

POST-OPERATIVE FORM

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

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

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

Patient Name: _____

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

OD

Cataract

1 month

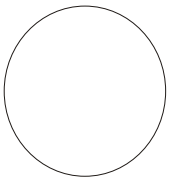
Other _____

UCVA *IOP*

20/ _____ _____ _____

M _____ _____ *X* _____ *20/*
C

Slit Lamp Exam



Medication: _____

Comments: _____

_____

OS

Cataract

1 month

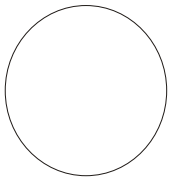
Other _____

UCVA *IOP*

20/ _____ _____ _____

M _____ _____ *X* _____ *20/*
C

Slit Lamp Exam



Medication: _____

Comments: _____

_____

Referring Physician: _____

Address: _____

Phone #: _____ **Fax #:** _____

Email: _____