

POST-OPERATIVE FORM

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

Dr. Herzig Dr. Eplett
 Dr. Taylor Dr. Ma

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

Next Appointment: _____ (MM/DD/YYYY)

Patient Name: _____

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

OD

PRK LASIK OTHER _____

_____ days 1 week 1 month 2 months

3 months 6 months Other _____

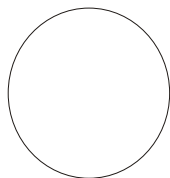
UCVA IOP Haze Rating

20/ _____ _____ _____

M _____ X _____ 20/
C _____

K _____ / _____ X _____

Slit Lamp Exam



Medication: _____

Comments: _____

OS

PRK LASIK OTHER _____

_____ days 1 week 1 month 2 months

3 months 6 months Other _____

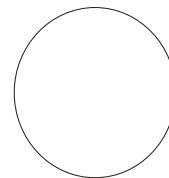
UCVA IOP Haze Rating

20/ _____ _____ _____

M _____ X _____ 20/
C _____

K _____ / _____ X _____

Slit Lamp Exam



Medication: _____

Comments: _____

Referring Physician: _____

Address: _____

Phone #: _____ Fax #: _____

Email: _____