HERZIG
EYE INSTITUTE

Post-Operative Form

PH: 416-929-2020
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Patient Name: ______________________________ **DOB:** ________________________________

Exam Date: ________________________________ **Next Appointment:** ____________________

OD	OS
SMILE LASIK PRK CXL	SMILE LASIK PRK CXL
RLE ICL Cataract	RLE ICL Cataract
____days ______weeks ______months	____days ______weeks ______months
Other:_________________________________	Other:_________________________________
UCVA **IOP**	**UCVA** **IOP**
20/_______ _______	20/_______ _______
MC _______ _______ X ____ 20/	**MC** _______ _______ X ____ 20/
Slit Lamp Exam:	**Slit Lamp Exam:**
Medication:___________________________	**Medication:** ___________________________
Comments:	**Comments:**

Referring Doctor:		**Billing Number:**
Address:		**Comments:**
Phone:	**Fax:**	
Email:		