SightMD®
eye doctors • eye surgeons

OD/MD to send to SightMD after each post-op appt
email to **comanage@sightmd.com** or fax to **(631) 924-3196**

POST-OPERATIVE ASSESSMENT

Patient Name: _____ Patient DOB: _____

Surgery Date: _____ OD/OS Procedure: _____

Surgery Date: _____ OD/OS Procedure: _____

Primary Eye Care Doctor: _____ Telephone: _____

Surgeon: _____ Telephone: _____

Post-Op Dates: 1-Week _____ 1-Month _____ Assessment: _____

				OD	OS
Visual Acuity (Uncorrected)				20/	20/
MR: OD				20/	
MR: OS					20/
IOP's (Applanate)				mmHg	mmHg
SLITLAMP:				OD	OS
Conj: Normal/					
Cornea: Normal/					
A/C: Normal/					
Iris: Normal/					
Lens: Normal/					

Medications/Dosages: _____

_____

_____

Assessment/Comments: _____

_____

_____

Appointment made for patient with Dr. _____ on _____ at _____

Additional instructions for patient: _____

_____

Examining Doctor: _____ Date: _____

PATIENTS MAY BE REFERRED BACK TO THEIR SURGEON AT ANY TIME AND FOR ANY REASON. IF THE PATIENT FAILS TO KEEP THEIR APPOINTMENT, PLEASE CALL US AT 855.295.4144 WITHIN 24 HOURS OF THE MISSED EXAM. PLEASE RETAIN A COPY FOR YOUR RECORDS.