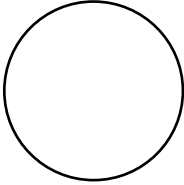
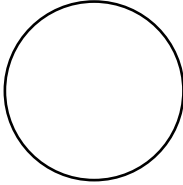


POST-OPERATIVE ASSESSMENT

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: _____