SIGNATURE EYE SPECIALISTS

Postoperative visit

From: _____

_____

_____

Phone: _____ Fax: _____

To:

☐ Dr. Bill Chow
☐ Dr. Yamina Cherif
☐ Cataract Consultation
☐ Corneal Consultation
☐ Other: _____

Please forward your findings by fax to: (403)254-5887

Patient Name: _____
Address: _____
AHC # _____
Phone (Daytime): _____

Date of surgery: OD _____
OS _____
Visit: OD ❑ 2 wk. ❑ 4 - 6 wk. ❑ other
OS ❑ 2 wk. ❑ 4 - 6 wk. ❑ other

Examination Findings

OD

ucva: _____ corrected va: _____
MR: _____/_____x_____ bcva: _____
keratometry: _____
IOP: _____ method: _____
ocular movement: _____
_____
lids & lashes: _____
_____
cornea: _____
_____
iris & pupil: _____
_____
lens: _____
_____
retina: _____

OS

ucva: _____ corrected va: _____
MR: _____/_____x_____ bcva: _____
keratometry: _____
IOP: _____ method: _____
ocular movement: _____
_____
lids & lashes: _____
_____
cornea: _____
_____
iris & pupil: _____
_____
lens: _____
_____
retina: _____

Comments

_____

_____