CLARITY
LASER VISION

POST-PROCEDURAL
FORM

Please fill out the infromation below & Fax this form to 403.640.0456

Referring Doctor: _____ Patient name: _____

Phone: _____ – _____ Date of birth: _____

Date of examination: _____ Phone: (HOME) _____ (WORK) _____

E-mail: _____

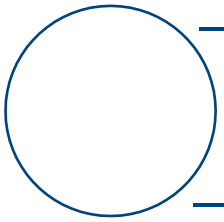
Post-Op Exam:

OD	☐ 1 WEEK	☐ 1 MONTH	☐ 4 MONTH	☐ 1 YEAR	☐ OTHER
OS	☐ 1 WEEK	☐ 1 MONTH	☐ 4 MONTH	☐ 1 YEAR	☐ OTHER

Post-Op Medication (Names): _____

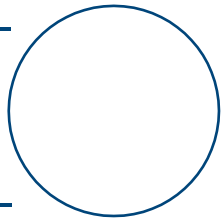
Comments/Chief Complaint: _____

OD			OS		
20/_____	J _____	UNCORRECTED VISION	20/_____	J _____	
_____	20/_____	MANIFEST REFRACTION	_____		20/_____



K's _____

_____ mmHg IOP's _____ mmHg



_____ SLIT LAMP EXAM _____

_____ FUNDUS _____

Advice to Patient: _____

Recommendation/Plan: _____

_____