HERZIG EYE INSTITUTE

TORONTO | OTTAWA

CLEAR FORM

Post-Operative Form

PH: 416-929-2020 (Toronto) 613-800-1680 (Ottawa)
Fax: 416-929-0232 (Toronto) 613-800-0718 (Ottawa)

Patient Name: _____ **DOB:** _____

Exam Date: _____ **Next Appointment:** _____

OD

☐ SMILE ☐ LASIK ☐ PRK ☐ CXL

☐ RLE ☐ ICL ☐ Cataract

____days _____weeks _____months

Other:_____

UCVA **IOP**

20/_____ _____

M _____ _____ X ____ 20/

C

Slit Lamp Exam:

Medication:_____

Comments:

OS

☐ SMILE ☐ LASIK ☐ PRK ☐ CXL

☐ RLE ☐ ICL ☐ Cataract

____days _____weeks _____months

Other:_____

UCVA **IOP**

20/_____ _____

M _____ _____ X ____ 20/

C

Slit Lamp Exam:

Medication: _____

Comments:

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