HORIZON EYE SPECIALISTS
& LASIK CENTER

Postoperative Cataract

Fax: 480-419-5401

Patient Name: _____ **DOB:** _____

Exam Date: _____ **Surgery Date:** _____ **Surgeon:** _____

Referring Doctor: _____

Uncorrected distance VA:

OD 20/___ OS 20/___ OU 20/___

Uncorrected near VA:

OD 20/___ OS 20/___ OU 20/___

IOP:

OD:___ **OS:**___ **Goldman** **NCT** **Tonopen** **Time:** __:__ **AM/PM**

Refraction:

OD _____ VA 20/___

OS _____ VA 20/___

Postoperative K's:

OD _____

OS _____

Pertinent SLE Findings:

OD _____

OS _____

Please Fax Post-Operative form to our office @ 480-419-5401
If you have any questions, please contact Shelby at (480) 513-6554