HORIZON EYE SPECIALISTS & LASIK CENTER

Laser Vision Correction – Comanagement Post-Operative Visit

Patient Name _____ Post Op Exam Date _____

Primary Care Optometrist _____ Surgeon _____

Post Op Exam for:

☐ 1 day ☐ 1-2 week ☐ 6-8 week ☐ 3 months

☐ 6months ☐ 12 months ☐ Other

Operative Eye:

☐ OD Surgery Date _____ Aim _____

☐ OS Surgery Date _____ Aim _____

VA/SC OD 20/_____ OS 20/_____ OU 20/_____

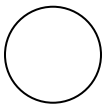
Near VA/SC OD 20/_____ OS 20/_____ OU 20/_____

Manifest Refraction: OD _____ x _____ = 20/_____
OS _____ x _____ = 20/_____

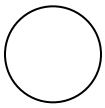
Post-Operative Medications:
OD_____ OS _____

Slit Lamp Exam

OD OS



_____ Cornea _____
_____ A/C _____
_____ Lens _____



Doctor comments: _____
_____

Doctor's Signature: _____

Please Fax Post-Operative form to our office @ 480-419-5401

*If you have any questions, please contact Shelby at (480) 513-6554 or our main line (602) 467-4966.