

## **Post-operative Evaluation**

Мо						_	nt Fees Rece			
	nth: 1 3	6 12 Oth	ner:		_ Pa	atient Name:				
Doctor Name:					_ Pl	Phone (H):				
Office Contact: Office Phone: Original Procedure Date: Enh. Procedure Date:										
					Bi	Birthdate: Age:				
										Pre.
	SPHERE	CYL.	AXIS	BCVA		SPHERE	CYL.	AXIS	BCVA	
OD				20/	OS				20/	
UC\	<b>/A</b> OD 20/	/ OS	5 20/	Patient Co	mment	ts:				
ubj	ective Refr		AVIC			CDLIEDE	CVI	AVIC		
) 	SPHERE	CYL.	AXIS	20/	OC	SPHERE	CYL.	AXIS	70/	
DD				20/	OS				20/	
Cyclo	pplegic Ref			t-operative exa	n if visior				ed.)	
	oplegic Ref	raction (At t	the 3 month pos AXIS	t-operative exa	m if visior	n is not satisfacto SPHERE	ry or if enhancem CYL.	nent is consider AXIS	ed.)	
				20/	OS [	SPHERE				
DD [		CYL.		20/	г	SPHERE				
DD [	SPHERE	CYL.		20/ I. Clear Haze	OS [	SPHERE  Clear  Haze				
DD [	SPHERE  amp Exam	CYL.		20/ L. Clear Haze Debris	OS [ O.P	SPHERE  Clear  Haze  Debris		AXIS		
DD [	SPHERE  amp Exam	CYL.		20/ I. Clear Haze	OS [ O.P	SPHERE  Clear  Haze		AXIS		
DD [	amp Exam OD	CYL.		20/  Clear  Haze  Debris Ingrowth	OS [ O.P	Clear Haze Debris		AXIS		
DD [ Slit L Meds	amp Exam OD Tobra	CYL.  dex □ Ar	AXIS	20/  Clear Haze Debris Ingrowth	OS [ O.P	SPHERE  Clear  Haze  Debris  ngrowth		AXIS		
DD [ Slit L Meds	amp Exam OD	CYL.  dex □ Ar	AXIS	20/  Clear Haze Debris Ingrowth	OS [ O.P	SPHERE  Clear  Haze  Debris  ngrowth		AXIS		
Slit L  Weds	amp Exam OD Tobra	CYL.	AXIS  Ttificial Tears	20/ Clear Haze Debris Ingrowth	OS [	SPHERE  Clear  Haze  Debris  ngrowth	CYL.	AXIS		