CONLON
EYE INSTITUTE

Post-Operative Form

PH: 306-244-4111
Fax: 306-244-9904

Patient Name: ____________________________ **DOB:** ______________________________

Exam Date: ______________________________ **Next Appointment:** __________________

OD

LASIK PRK Retreat

RLE Cataract

____days ______weeks ______months

Other:_________________________________

UCVA **UCNVA** **IOP**

20/_____ **20/_____**

M _______ _______ X ____ 20/

Slit Lamp Exam:

Medication:

Comments:

OS

LASIK PRK Retreat

RLE Cataract

____days ______weeks ______months

Other:_________________________________

UCVA **UCNVA** **IOP**

20/______ **20/____**

M _______ _______ X ____ 20/

Slit Lamp Exam:

Medication:

Comments:

Referring Doctor:______________________________________ **Date:**_____________________