MALONEY VISION INSTITUTE

POSTOPERATIVE FORM

Please fax to (310) 208-0169 or email to: cm@maloneyvision.com

Referring Doctor: _____ **Follow-up Exam Date:** _____

Patient's Name: _____ **Procedure Date: OD** _____ **OS** _____

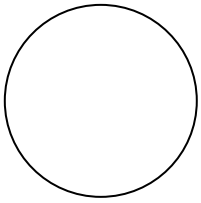
Postoperative Exam: **OD** ❑ 1 day ❑1 week ❑1 month ❑3 months _____ Other

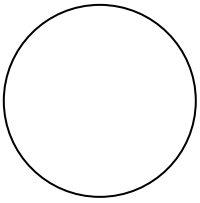
OS ❑ 1 day ❑1 week ❑1 month ❑3 months _____ Other

CC: _____

_____

EXAMINATION	OD	OS
UCVA	OD 20/ _____ Int/ _____ J / _____ OU 20/ _____ Int/ _____ J / _____	OS 20/ _____ Int/ _____ J / _____
Manifest Refraction (dim lights)	_____20/ _____	_____20/ _____
Other / IOP	_____	_____
Slit Lamp	_____	_____
Fundus	_____	_____





Impression/Plan: _____

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_____

Doctor's Signature: _____

For MVI Use Only:

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