BERG·FEINFIELD
VISION CORRECTION

CO-MANAGEMENT POST-OPERATIVE FORM

Name:_____ DOB:____/____/____Age:_____Sex:M/F

Referring Doctor:_____ Office Phone #:_____
Office Fax #:_____

Surgery Date:_____/_____/_____ Procedure/Eye:_____

Date of Post-op Exam: _____/_____/_____

OD ☐ 1 day ☐ 2 week ☐ 1 month ☐ 3 months ☐ other:_____

OS ☐ 1 day ☐ 2 week ☐ 1 month ☐ 3 months ☐ other:_____

Chief Complaint/Comments:_____
Current Medications:_____
Allergies:_____

Examination

OD		OS
_____	**Corrected Visual Acuity**	_____
_____	**Uncorrected Visual Acuity**	_____
_____20/____	**Manifest Refraction**	_____20/____
_____	**Keratometry/Topography**	_____
_____mm/Hg (time:)	**IOP**	_____mm/Hg (time:)

Patient comments:_____

Doctor comments/plan:_____

_____

_____

Questions to Surgeon:_____

_____

_____

Doctor's Signature:_____

PLEASE FAX POST-OPERATIVE FORM TO APPROPRIATE DEPARTMENT:
LASIK DEPARTMENT at (818) 845-1916 or
SURGERY DEPARTMENT at (818) 845-5205.

Revised January 2010 /il