BERG·FEINFIELD
VISION CORRECTION

Co-management Post-Operative Form

Last Name:_____ First Name:_____ Age: _____

Gender: _____ Date of Birth: _____/_____/_____

Referring OD: _____ Office Phone: _____

OD Email: _____ Office Fax: _____

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

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

OD ❒1 day ❒2 week ❒1 month ❒3 month ❒other: _____

OS ❒1 day ❒2 week ❒1 month ❒3 month ❒other: _____

Examination

OD ***OS***

_____ Corrected Visual Acuity _____

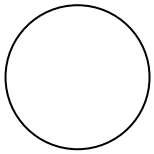
_____20/____ Uncorrected Visual Acuity _____20/____

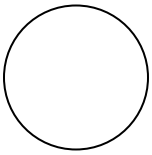
_____20/___ Add:____ Manifest Refraction _____20/___ Add:____

_____ mm/Hg (time: _____) IOP _____ mm/Hg (time: _____)

Slip Lamp Exam

Cornea:

SOS  Folds

SOS  Folds

Patient Comments: _____

Doctor comments/plan: _____

_____

_____

Questions to Surgeon: _____

_____

_____

Doctor Signature: _____

PLEASE SEND POST-OPERATIVE FORM TO BFVC:
FAX TO 818.845.1916 OR EMAIL TO INFO@BERGFEINFIELD.COM