ChuVision INSTITUTE

Post-op Report

Kindly mail, e-mail or fax your exam findings. We rely on this data and appreciate your help.

REFERRING DOCTOR

Name_____

Phone_____

Location_____

Date of Exam_____

PATIENT INFORMATION

Name _____

Date of Birth _____

Date of Surgery OD_____

OS_____

Type of Surgery ☐ LASIK ☐ ASA ☐ Cataract ☐ Crystalens ☐ Toric ☐ Yag ☐ Other _____

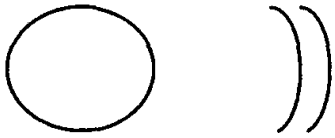
Eye(s) ☐OD ☐OU ☐OS

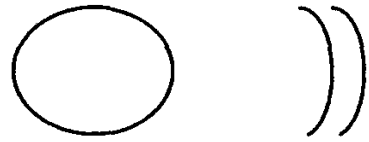
Reason for Visit: _____

Visual Acuities:

OD: 20/_____ OS: 20/_____ OU: 20/_____

MRX: MRX:





Pressures:

OD_____mmHg OS_____mmHg at time: _____

Assessment:

☐ S/P LASIK OU/OD/OS ☐ S/P Cataract Extraction/IOL OU/OD/OS ☐ Crystalens OU/OD/OS

☐ S/P ASA OU/OD/OS ☐ Post. Cap. Opacification OU/OD/OS ☐ Toric OU/OD/OS

☐ S/P Yag Capsulotomy OU/OD/OS ☐ Dry Eye Syndrome ☐ Other:_____

_____

_____

_____

Plan:_____

_____

_____

Medications: _____QD/BID/TID/QID/PRN _____QD/BID/TID/QID/PRN _____QD/BID/TID/QID/PRN

_____QD/BID/TID/QID/PRN _____QD/BID/TID/QID/PRN _____QD/BID/TID/QID/PRN

Please contact us by telephone if you need assistance with any post-operative condition

Physician Name_____ **Signed** _____

Please Print

CVI Phone 952.835.1235

Fax to CVI at 952.835.0534

Electronic forms are available at www.chuvision.com/eyecare-professionals