SISKIYOU EYE CENTER

POSTOPERATIVE EXAM REPORT

TO: DOCTOR _____

Patient: _____ Date of Birth _____

Examination Date _____

EXAM

Visual Acuity:			*How Long Postop*	
OD 20 /	**OS** 20 /	w/o correction	*1 Week*	*1 Month*
OD 20 /	**OS** 20 /	w/correction	*1 Week*	*1 Month*
IOP OD	IOP OS			

	Sph	**Cyl**	**Axis**	**VA**
OD				
OS				

SLE / FUNDUS WNL OU Additional findings noted below

OD _____ OS _____

Plan:

Meds Acular QID PredForte QID Other:

Comments

☐ We will contact surgery scheduler at 541-482-8100 Ashland or 530-842-2760 Yreka to arrange 2nd eye surgery.

☐ Surgeon please contact patient to arrange 2nd eye surgery

2nd Eye ADL (Activity of Daily Living difficulties) _____

Signature_____

Please fax all postoperative exam reports to (Ashland) 541-488-5081 (Yreka) 530-842-5839.
Please contact the surgeon immediately at 541-482-8100 for any medical or surgical concerns.
Contact Bel Borg at 541-482-8100 if you have any questions.