EVERGREEN EYE CENTER

Leading-edge, patient-centered care.

POST OPERATIVE REPORT

eFax to 855-929-1515

❍ 1 WEEK ❍ 1 MONTH ❍ 4 MONTHS ❍ 12 MONTHS

Patient Name: _____

Date of Birth: _____

Date of Surgery: _____

Examining Physician: _____

Date of Exam: _____

Right Eye

Uncorrected DIST VA 20/_____ INT VA _____ Near VA _____

Refraction _____ - _____ 20/_____

Left Eye

Uncorrected DIST VA 20/_____ INT VA _____ Near VA _____

Refraction _____ - _____ 20/_____

Exam Information: _____

_____

_____

_____

On a scale of 1 to 5, with five being very satisfied and 1 being very dissatisfied, how do you rate this patient's satisfaction with their surgical experiences so far?

1 ★ 2 ★★ 3 ★★★ 4 ★★★★ 5 ★★★★★

Comments: _____

_____

_____

Thank you for sharing the findings from your post-op exam. The details you provide on this patient will help us ensure they have the maximum outcome.

www.EvergreenEye.com