CLARITI
ADVANCED VISION CORRECTION

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Post Operative Exam Form

__LASIK/PRK ___ICL ___Monofocal Lens ___Toric Lens ___crystalens
Date of Surgery: OD _____ OS _____
Comanaging Doctor: _____
Patient Name: _____ DOB: _____

Date: _____ Vigamox _____ Econopred ____ Nevanac ____ Tears ____	sc DVA OD _____ OS _____ OU _____ sc IVA OD _____ OS _____ sc NVA OD _____ OS _____ OD _____20/____ OS _____ 20/____ IOP _____ / _____ ___conj___ ___cornea___ ____AC____ ___lens___	Impression: Plan: Signed:

Date: _____ Vigamox _____ Econopred ____ Nevanac ____ Tears ____	sc DVA OD _____ OS _____ OU _____ sc IVA OD _____ OS _____ sc NVA OD _____ OS _____ OD _____20/____ OS _____20/____ IOP _____ / _____ ___conj___ ___cornea___ ____AC____ ___lens___	Impression: Plan: Signed: