CLEARVIEW VISION INSTITUTE

POST-OPERATIVE REPORT

Patient Name: ____________________

Address: ____________________

Health Card #: ____________________ Version Code: __________

Date of Birth: ____________________ Age: ______ ☐ Male ☐ Female

Home Phone: ____________________ Mobile: ____________________

OD	OS
☐ RLE ☐ Monofocal ☐ Multifocal ☐ CLE ☐ LASIK ☐ PRK ☐ SMILE	☐ RLE ☐ Monofocal ☐ Multifocal ☐ CLE ☐ LASIK ☐ PRK ☐ SMILE
☐ UCVA ______ ☐ UCDVA ______ ☐ UCNVA ______ ☐ REFRACTION ______ ☐ IOP ______ ☐ KERATOMETRY ______	☐ UCVA ______ ☐ UCDVA ______ ☐ UCNVA ______ ☐ REFRACTION ______ ☐ IOP ______ ☐ KERATOMETRY ______
SLIT LAMP EXAM:	SLIT LAMP EXAM:

ADDITIONAL COMMENTS:

Referring Doctor ____________________ Date __________

Address ____________________

Phone ____________________ Fax ____________________

Email ____________________

Please fax back to Clearview Institute at 416-289-2318 after each visit. Thank you.