MALONEY VISION INSTITUTE

COMANAGEMENT POST-PROCEDURAL FORM

Please **Fax** to **(310) 208-0169** or mail to: 10921 Wilshire Blvd. Suite 900, LA, CA 90024 / **Attention: Michael Civitano**

Co-Managing Dr. ______________________________ **Follow-up Exam Date** ______________

Patient's Name ______________________________ **Procedure Date: OS** ________ **OD** ________

Post-Procedural Exam

OD	☐ 1 day	☐ 1 week	☐ 1 month	☐ 3 months	________ Other
OS	☐ 1 day	☐ 1 week	☐ 1 month	☐ 3 months	________ Other

CC: ____

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EXAMINATION	**OD**	**OS**
Uncorrected VA (lights on)	20/ ________ J ________	20/ ________ J ________
Manifest Refraction (dim lights)	____________ 20/ ____	____________ 20/ ____
Other / IOP	____________	____________
Slit Lamp	____________	____________
Fundus	____________	____________

Notes:

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Co-Managing Doctor's Signature

For MVI Use Only

Dear Doctor ______________________ **Date:** ______________

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Director of Clinical Care: ______________________