WHATCOM EYE SURGEONS

A Division of Northwest Eye Surgeons of Seattle

Surgery Follow-Up Report

At WES, we are committed to supporting and promoting healthy surgical and medical co-management policies. One responsibility we share involves communication between our offices. We appreciate your prompt completion and return of these forms to our offices, preferably by fax. This information is vital to maintaining the highest standard of cataract care for your patients. Thank you.

Patient Name: _____ DOB: _____ Appt Date: _____

Surgery Date: _____ Consulting WES Physician: _____

Type of Surgery: _____

Additional History: _____

_____

Is the patient happy with surgical results and experience at Whatcom Eye Surgeons? _____

_____

Post-Op Visit (check)

OD ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 _____ Day _____ Week _____ Month _____ Year

OS ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 _____ Day _____ Week _____ Month _____ Year

Visual Acuity:

	Unaided	Pinhole	Unaided Near 16"	Unaided Near 32"
OD	20/_____	20/_____	20/_____	20/_____
OS	20/_____	20/_____	20/_____	20/_____
OU	20/_____	20/_____	20/_____	20/_____

Tonometry: (_____ ❑AM ❑PM)

(_____ method)

OD _____

OS _____

Refraction:

OD _____-_____X_____ 20/_____

OS _____-_____X_____ 20/_____

Examination Information:

Visual/Lifestyle Complaint for 2nd Eye Surgery: _____

_____

Next Visit: Date/Time _____ Doctor: _____

Referring Doctor: _____ Phone: _____

Address: _____

Please mail or fax to us:

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