Co-Management Postoperative Form

Please fax or email to:

GORDON SCHANZLIN
NEW VISION INSTITUTE

8910 University Center Lane, Suite 800, San Diego, CA 92122
Phone (858) 455-6800 Fax (858) 455-0244 e-mail rmartin@gwsvision.com

☐ Please Call Optometrist @_____

Referring Doctor_____ Phone_____ Date_____

Patient Name:_____ DOB_____

Pre-op Rx OD		Procedure:	
Pre-op Rx OS		Procedure :	
Meds:	Frequency	Eye	Other OHX
CC:			
	Far	Intermediate 32”	Near 16”
SC OD			
SC OS			
Manifest OD		20/	TA /
OS		20/	@
K’s OD		OS	
OD		OS	
SLE:			
Cornea			
A/C			
Lens			
		Tech:	
		Gtts:	
Imp/Dx:			
Plan/ Comments:			
Return:		Doctor’s Signature:	

M. Gordon M.D. D. Schanzlin M.D A. Gordon M.D. J. Echegoyen, M.D