Please schedule return appointment in:

- ❏ _____ day(s) ❏ _____ week(s) ❏ _____ month(s)

Reason for return visit:

- ❏ Refraction Check
- ❏ Contact Lens Follow Up
- ❏ Emergency Follow Up
- ❏ Post-Op Follow Up: ________________
- ❏ Glaucoma Evaluation
- ❏ Macular Degeneration Evaluation
- ❏ Dry Eye Evaluation
- ❏ Retina-Vitreous Evaluation

Additional testing needed:

- ❏ Gonioscopy
- ❏ Pachymetry
- ❏ Slit Lamp Photography
- ❏ Retinal Camera Photography
- ❏ OCT: ______________________
- ❏ Visual Field: _________________

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