Please so	chedule return appointment in:			
	day(s)	□ week(s)		□ month(s)
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Reason f	for return visit:			
	Refraction Check			Glaucoma Evaluation
_	Contact Lens Follow Up			Macular Degeneration Evaluation
_	•		_	=
	Emergency Follow Up			Dry Eye Evaluation
	Post-Op Follow Up:			Retina-Vitreous Evaluation
Addition	nal testing needed:			
	Gonioscopy			Retinal Camera Photography
	Pachymetry			OCT:
	Slit Lamp Photography			Visual Field:
Please so	chedule return appointment in:			
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