REFRACTIVE SURGERY CLINIC

Naval Hospital Bremerton, Washington

NAME_____
Phone #_____
FAX #_____
Date:_____

DATE of PRE-OP exam (dilated) _____

I understand that it is mandatory that I attend the consent prior to the surgery, otherwise I will not receive surgery. My **CONSENT TIME** and **DATE** is _____
AT: (location) _____.

My **SURGERY TIME** and **DATE** is:_____
AT _____.

I understand that there will be **post-operative follow up appointments** that I am expected to attend. All follow-up appointments will be at Naval Hospital Bremerton or with your local eye care provider who referred you for surgery.

*** If any questions, concerns, or change in schedule, please call the Refractive Surgery Clinic at 360-475-4295.

Patient signature _____

Refractive surgery staff initials _____

NHBREM 6220/4(11-02)
ORIGINATOR: OPHTHALMOLOGY
MEDICAL RECORD JACKET