EYE _____ DOB _____ INS _____

PCP _____ DOS _____

CATARACT SURGERY SCHEDULE SHEET

STEVEN R. BRUSIE, M.D.
190 GROTON ROAD
SUITE 240
AYER, MA 01432
978-772-4000

PATIENT NAME _____

ULTRASOUND DATE:

_____ AT _____

PRE-OP DATE/PRE-ADMISSION WILL BE DONE AT NASHOBA VALLEY MEDICAL CENTER ON YOUR PRE-OP DATE:

_____ AT _____

SURGERY DATE (WEDNESDAY) :

_____ AT _____

FIRST POST-OP DATE (ONE DAY AFTER SURGERY):

_____ AT _____

SECOND POST-OP DATE (ONE WEEK AFTER SURGERY, YOU WILL BE REFRACTED):

_____ AT _____

THIRD POST-OP DATE (ONE MONTH AFTER SURGERY, YOU WILL BE REFRACTED AND DILATED):

_____ AT _____

YOU MUST CALL YOUR FAMILY PHYSICIAN FOR A PRE-OPERATIVE PHYSICAL

BETWEEN _____ AND _____

NAME OF LOCAL PHARMACY WHERE YOU WOULD LIKE TO PURCHASE YOUR PRE-OP EYE DROPS:

_____

_____