



Portland NEUROSURGERY

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Postoperative Visit

Name _____

Date of Birth _____

Primary Care Provider _____

Today's date _____

Have you returned to work? Yes – restricted Yes – unrestricted No Not applicable

Do you need any of the following today? (Please check all that apply)

- Prescription refills _____
- Work Release
- Handicap Parking
- FMLA forms
- Other _____