

Cataract Surgery Referral



REFERRING DOCTOR

Name _____
Address _____
Phone (____) _____

PATIENT INFORMATION

Name _____
Address _____
Date of Birth _____

Date of Exam _____ Phone: Hm (____) _____ Wk (____) _____

Lens implant desired: Standard single-focus IOL Toric IOL Multifocal IOL

Motivation to be less dependent on glasses: Low Medium High

What refractive error outcome do you recommend for each eye? OD _____ OS _____

If monovision correction is requested, has patient undergone a contact lens trial? Yes No

Chief visual complaint: Reading Driving Hobbies Glare Other

Occupation _____ Hobbies _____

SUBJECTIVE

Ocular history (i.e. injury, amblyopia, previous surgery, other) _____

Previous refractive surgery (i.e. CK, RK, PRK, LASIK, other) _____

Medical history (i.e. diabetes, heart, lung, arthritis, lupus, other) _____

Medications: Ocular _____ Systemic _____

Allergies _____

OBJECTIVE

Important Note: Rigid or gas perm contacts must be left out at least 3 weeks prior to exam and soft contacts 7 days prior.

Dominant Eye: OD OS

OD

OS

Pupil Size (diameter in dim and bright light) _____ / _____ mm (dim/bright) APD + / - (circle) _____ / _____ mm (dim/bright) APD + / - (circle)

Best Corrected VA 20 / _____ 20 / _____

Present Rx: CL Glasses (add _____) _____ 20 / _____ 20 / _____

Dry Refraction (date if not today _____) _____ 20 / _____ 20 / _____

Keratometry Readings: Manual Auto _____ @ _____ @ _____ @ _____ @ _____

IOP: Air Applanation Other _____ mm Hg _____ mm Hg

Corneal Thickness (if known) _____ microns _____ microns

Ocular Motility _____

Check if normal:

OD OS

- Adnexa
- Lids/lashes
- Conjunctiva
- Cornea
- AC
- Iris

OD OS

- Lens
- Vitreous
- Disc
- Vessels
- Macula
- Periphery

Anterior segment abnormal findings

Posterior segment abnormal findings

Visual Field Enclosed: Yes No

ASSESSMENT

PLAN

I have scheduled this patient to be seen at PCLI on: (date) _____ at (time) _____ .

I would like PCLI to phone this patient to schedule an appointment.

PATIENT SHARED BILLING

Patient desires toric or multifocal IOLs and is aware of the extra costs. If deemed a suitable candidate, they are prepared to pay out-of-pocket for non-covered extra services. Please note that our same-day evaluation and surgery are not possible with these IOLs.

Signed _____

Referring Doctor