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Medical Necessity for Cataract Surgery

Date:	Chart #
Patient Name:	DOB:
Reason for exam.	
What Specific improvements in your daily life do you hope to gain with surgery?	
Best corrected Vision- (Snellen) Distance 20/___ 20/___ (with blinking, good light & proper bifocal)	Near 20/___ 20/___ Medium BAT 20/___ 20/___ (if glare symptoms)

Visual Function Status Complete all questions	**Circle your Responses**	
1) Do you have difficulty seeing street signs or driving? (freeway exits, curbs, traffic lights, glare or halos when driving at night)	YES	NO
2) Do you have difficulty seeing the TV? (Numbers, faces, TV guide, or print)	YES	NO
3) Do you have difficulty reading small print when in good lighting, proper glasses and complete blinking? (medicine labels, instructions, books or newspaper)	YES	NO
4) Do you have difficulty performing detailed work? (Sewing, baiting a fish hook or other fine tasks)	YES	NO
5) Do you have difficulty with personal correspondences? (writing checks, filling out forms, e-mail or letters)	YES	NO
6) Do you have difficulty with leisure activities such as sports or hobbies? (Playing cards, painting, drawing or sports: hunting, golf tennis or bowling)	YES	NO
7) Do you have visual difficulty functioning around the house? (cooking, ironing, household upkeep, climbing steps, telling time on a A watch or clock)	YES	NO
8) Do you have difficulty recognizing faces? (in church, grocery store, neighbors or during other daily activities)	YES	NO
9) If you live alone and wish to remain independent, are you unable to care for yourself with your present vision?	YES	NO

Do you have any of the following <u>VISUAL SYMPTOMS?</u>		
1) Worsening or blurred vision?	YES	NO
2) Glare, rings or halos around lights?	YES	NO
3) Difficulty with color perception? (colors are not as bright or vibrant)	YES	NO
4) Difficulty with Depth perception? (walking up and down stairs)	YES	NO
5) Double or distorted vision?	YES	NO

☐ RIGHT EYE Patient Signature _____ LEFT EYE ☐