Eye Associates of Central Texas

Medical Necessity for Cataract Surgery

Date: _____/_____/_____ Surgery Date: _____/_____/_____

Patient Name: _____ Eye: _____

Reason for exam today (patient words) _____

_____

_____

What specific improvements in your daily life do you hope to gain with surgery? _____

_____

_____

Best corrected Snellen VA – Distance: 20/
With blinking, good light and proper bifocal **20/**

Near: Medium BAT if glare symptoms: 20/
20/

_____

_____

Visual Functional Status

(Complete all lines — Circle all Responses)

Do you have difficulty driving or seeing street signs? *(curbs, freeway exits, traffic lights, halos/glare around lights)*	Yes	No
Do you have difficulty seeing TV or movies? *(faces, numbers, or printing)*	Yes	No
Do you have difficulty reading small print with good light, complete blinking and proper glasses? *(books, newspapers, telephone books, medicine labels, instructions)*	Yes	No
Do you have difficulty performing detailed work? *(sewing, knitting, crocheting, embroidery, baiting a fish hook or other fine tasks)*	Yes	No
Do you have difficulty with personal correspondences? *(writing checks, reading bills, filling out forms)*	Yes	No
Do you have difficulty with leisure activities such as sports or hobbies? *(playing card games, bingo, dominoes, or sport activities such as bowling, hunting, golf, tennis, other* _____*)*	Yes	No
Do you have visual difficulty functioning around the house? *(cooking, ironing, general household upkeep, climbing steps or curbs, dialing the telephone, telling time on a watch, using public transportation)*	Yes	No
Do you have difficulty recognizing faces of people? *(in church, grocery store, clubs, and other daily activities)*	Yes	No
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 Visual Symptoms?

Double or distorted vision?	Yes	No
Glare, halos, rings around lights?	Yes	No
Difficulty with color perception?	Yes	No

Difficulty with depth perception?	Yes	No
Worsening of vision – blurred vision?	Yes	No

☐ Right Eye
☐ Lefft Eye

Patient Signature: X _____ Date: _____/_____/_____

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