ADULT WITH VISUALLY
SYMPTOMATIC CATARACT

Patient Name: _____

Ophthalmologists, hospitals and outpatient surgery centers (ASCs) must maintain notes or medical records outlining an appropriate preoperative ophthalmic evaluation and any related ancillary testing as appropriate. It is required that this form be completed and provided to the surgical facility to ensure it can meet its documentation requirements.

Specific activity limitations and/or participation restrictions. Use patient's own words where possible.

- ☐ Diminshed comfort driving in daylight
- ☐ Decreased comfort driving at night
- ☐ Increased dificulty reading
- ☐ Bothersome glare, halo, night vision issues
- ☐ Diminished comfort with regular daily activities
- ☐ Difficulty walking, seing curbs and/or breaks in sidewalk pavement

Best corrected distance visual acuity:

Right Eye 20/ _____ Near Acuity: _____

Left Eye 20/ _____ Near Acuity: _____

I certify that our office medical record shows the following:

- ☐ The patient's impairment of vision is believed not to be correctable with tolerable change in glasses or contact lenses.
- ☐ Cataract (in the operative eye) is believed to be significantly contributing to my visual impairment.

I, _____ , desire surgical correction. The risks, benefits and alternatives have been explained, and a resonable expectation exists that lens surgery will significantly improve both the visual and functional status of my vision.

Attestation

I certify that the above statements are true to the best of my knowledge.

Patient Signature: _____ **Date:** _____

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