Medical Necessity for Cataract Surgery

Date				Chart #	
Patient Name					
Reason for exam today (patient's words)					
What specific improvements in your daily life do you hope to gain with surgery?					
Best corrected Snellen VA - Distance	20/	Near	Medium BAT if glare symptoms:	20/	
	20/			20/	
With blinking, good light and proper bifocal.					

	Visual Functional Status ***(circle responses)***	Complete all lines	
1)	Do you have difficulty seeing street signs or to drive? (curbs, freeway exits, traffic lights, halos/glare around lights)	YES	NO
2)	Do you have difficulty seeing TV or movies? (faces, numbers, or printing)	YES	NO
3)	Do you have difficulty reading small print with good light, blinking and proper glasses? (books, newspaper, telephone book, medicine labels, instructions)	YES	NO
4)	Do you have difficulty performing detailed work? (sewing, knitting, crocheting, embroidery, bating a fish hook or other fine task)	YES	NO
5)	Do you have difficulty with personal correspondences? (writing checks, reading bills, filling out forms)	YES	NO
6)	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
7)	Do you have visual difficulty functioning around the house? (cooking, ironing, general household upkeep, climbing steps or curbs, dialing telephone, telling time on watch, using public transportation)	YES	NO
8)	Are you unable to see and recognize faces of people? (in church, grocery store, clubs, and 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 **VISUAL SYMPTOMS?**	Complete all lines	
1)	Double or distorted vision?	YES	NO
2)	Glare, halos, rings around lights?	YES	NO
3)	Difficulty with color perception?	YES	NO
4)	Difficulty with depth perception?	YES	NO
5)	Worsening of vision -- blurred vision?	YES	NO

Right Eye Patient Signature _____ **Left Eye**

Medical Necessity for Cataract Surgery La Necesidad Médica para la Cirugía de Catarata

Date/Fecha	*Chart Number*/Hoja Clínica
Patient Name/Nombre del Paciente	
Reason for exam today (patient's words)/ Razón para el examen de hoy (las palabras del paciente)	
What specific improvements in your daily life do you hope to gain with surgery? ¿Qué beneficios específicos espera obtener en su vida diaria como resultado de la cirugía?	

Best corrected Snellen visual acuity - Distance Mejor corrección de Agudeza Visual de Snellen A Una Distancia	20/ 20/	***Near*** De Cerca	***Medium BAT if Glare Symptoms*** Examen de Agudeza con Brillo Mediano, si existen síntomas de brillo excesivo	20/ 20/	

With blinking, good light, and proper bifocal /Al parpadear, en buena luz, y bifocales adecuadas

	Visual Function Status (circle responses) **Condición de Función Visual (circle las respuestas)**	*Complete all lines* Complete todas las líneas	
1	*Do you have difficulty seeing street signs or to drive? (curbs, freeway exits, traffic lights, halos/glare around lights)* ¿Se le dificulta ver las señales de tráfico o conducir? (bordillos, salidas de las autopistas, semáforos, halos/ brillo excesivo alrededor de las luces)	*Yes*/Sí	No
2	*Do you have difficulty seeing TV or movies? (faces, numbers, or text)* ¿Se le dificulta ver el televisor o ver películas? (caras, números, o texto)	*Yes*/Sí	No
3	*Do you have difficulty reading small print with good light, blinking, and proper glasses? (books, newspaper, telephone directory, medicine labels, instructions)* ¿Se le dificulta leer letras pequeñas con buena luz, parpadeando, y con lentes adecuados? (libros, periódicos, directorio telefónico, etiquetas de los medicamentos, instrucciones)	*Yes*/Sí	No
4	*Do you have difficulty performing detailed work? (sewing, knitting, crocheting, embroidery, baiting a fish hook, or other fine task)* ¿Se le dificulta hacer tareas detalladas? (costura, tejer con agujas, tejer al crochet, bordado, preparar un anzuelo de pesca, u otras tareas de detalle)	*Yes*/Sí	No
5	*Do you have difficulty with personal correspondence? (writing checks, reading bills, filling out forms)* ¿Se le dificulta atender su correspondencia personal? (emitir cheques, leer facturas/cuentas, llenar formularios)	*Yes*/Sí	No
6	*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 _____)* ¿Se le dificulta las actividades de tiempo libre, como deportes o pasatiempos? (barajas, bingo, dominó, o actividades deportivas tal como boliche, cacería, golf, tenis, otra _____)	*Yes*/Sí	No
7	*Do you have difficulty functioning around the house? (cooking, ironing, general household upkeep, climbing steps or curbs, dialing the telephone, telling time on watch, using public transportation)* ¿Se le dificulta funcionar en casa? (cocinar, planchar, el mantenimiento general de la casa, subir escaleras o bordillos, marcar el teléfono, ver la hora en su reloj pulsera, utilizando la transportación pública)	*Yes*/Sí	No
8	*Do you have difficulty seeing and recognizing faces of people? (in church, grocery store, clubs, and other daily activities)* ¿Se le dificulta ver y reconocer las caras de las personas? (en la iglesia, la tienda, clubes sociales, y otros lugares de actividades diarias)	*Yes*/Sí	No
9	*If you live alone and wish to remain independent, are you unable to care for yourself with your present vision?* Si usted vive solo y desea permanecer independiente, es usted incapaz de cuidarse a sí mismo con su visión actual?	*Yes*/Sí	No

	Do you have any of the following VISUAL SYMPTOMS? **¿Tiene algunos de las siguientes SÍNTOMAS VISUALES?**	*Complete all lines* Complete todas las líneas	
1	*Double or distorted vision?* ¿Visión doble o visión distorsionada?	*Yes*/Sí	No
2	*Glare, halos, or rings around lights?* ¿Brillo excesivo, halos, o anillos brillantes alrededor de las luces?	*Yes*/Sí	No
3	*Difficulty with color perception?* ¿Dificultad con la percepción de colores?	*Yes*/Sí	No
4	*Difficulty with depth perception?* ¿Dificultad con la percepción de profundidad?	*Yes*/Sí	No
5	*Worsening of vision or blurred vision?* ¿Empeoramiento de la visión o visión borrosa?	*Yes*/Sí	No

Right Eye **Ojo Derecho**

Patient Signature **Firma del Paciente** _____

Left Eye **Ojo Izquierdo**