Medical Necessity for Cataract Surgery

Date:			Chart #:		
Patient Name:					
To be filled out by your doctor:					
Best corrected Snellen VA-	20/	Near	Glare Vision-	20/	
	20/	Near		20/	
With blinking, good light, and proper bifocal					

Visual Functional Status (please complete all lines)	Circle Response	
1. Do you have difficulty seeing street signs or driving? (curbs, freeway exits, traffic lights, halos/glare around lights)	Yes	No
2. Do you have difficulties in seeing TV or movies? (face, numbers, or printing)	Yes	No
3. Do you have difficulty reading small print with good light, blinking, and proper glasses? (laptop, cellphone, iPad, books, newspaper, medicine labels)	Yes	No
4. Do you have difficulty performing detailed work? (sewing, embroidery, baiting a fish hook, or other fine tasks)	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 cards, bingo, computer games, or sport activities such as bowling, golf, tennis, other _____)	Yes	No
7. Do you have visual difficulty functioning around the house? (cooking, ironing, climbing steps or curbs, reading watch, using public transportation)	Yes	No
8. Are you unable to see and recognize faces of other 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**?	Circle Response	
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

Patient Signature: _____ Right eye Left eye