OMNI EYE SERVICES

SAME DAY CATARACT SURGERY PATIENT INFORMATION FORM

Patient Name _____ Patient Phone #:_____

Date of Birth_____ REFERRING OD NAME/PHONE:_____

Best Corrected VA OD _____ with refraction of _____+_____x_____

OS_____with refraction of _____ +_____ x _____

Postop refractive goal (sphere) OD_____, OS_____

Please circle answers:

Patient is a high myope (>6D) or high hyperope (>5D)? YES NO

Patient has retinal disease or prior retinal surgery? YES NO specific condition_____

Patient currently getting VEGF injections? YES NO

IF YES to any of the above, retinal clearance/approval for cataract surgery usually required and/or patient might not be candidate for TriMoxi injection (drops needed)

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Is patient a candidate for/interested in a premium lens? YES NO

If yes, is patient a candidate for (circle all that apply) TORIC VIVITY PANOPTIX

Is patient a past successful Monovision patient? YES NO if YES, RIGHT EYE Distance/Near

LEFT EYE Distance/Near

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Is patient allergic to fluoroquinolones such as Cipro/Levaquin? YES NO

Is patient allergic to steroids or a steroid responder? YES NO

IF YES, THIS IS A PATIENT THAT WILL NEED EYEDROPS CALLED IN FOR USE 3 DAYS PRIOR TO SURGERY, either Tobramycin or Azasite QID for 3 days prior to surgery and NSAID before and after surgery. IF PATIENT ARRIVES FOR SAMEDAY NOT ON ANTIBIOTIC DROPS, WE WILL HAVE TO CANCEL THE CASE

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Is patient a contact lens wearer? YES NO Soft CL (must be out for one week minimum)

YES NO Hard CL (not candidate for same day surgery)

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Patient has mature cataract, history of eye trauma, or severe glaucoma? YES NO

If YES, patient is not a same day surgery candidate

****Please fax this sheet to the North Office at 404-843-8521 ATTN: ERICA to schedule the patient****