



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)

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

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

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)

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

Has patient had LASIK or other refractive surgery? YES NO

If YES to either, 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****