K. Randy Pierce, MD
Mark A. Plunkett, MD
Eric Dai, MD
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EYE PHYSICIANS OF AUSTIN
Advanced Eye Care

Dawn C. Buckingham, MD
Peter T. Wollan, MD
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Medical Necessity for Cataract Surgery – To be completed by physician office

Date	Medical Record#
Patient Name	
Right Eye Left Eye	
Best corrected Snellen VA-Distance 20/ Near Medium BAT if glare symptoms: 20/ 20/ 20/ *With blinking, good light and proper bifocal*	

To Be Completed by Patient
****If you normally wear glasses, please answer below questions as if you were wearing your glasses****

Visual Functional Status (circle responses)	**Complete all lines**
Reason for exam today (patient's words)	
What specific improvements in your daily life do you hope to gain with surgery?	
1) Do you have difficulty seeing TV or movies?(faces, numbers or printing)	YES NO
2) Do you have difficulty reading small print with good light, blinking and proper glasses?(books, newspaper, telephone book, medicine labels, instructions)	YES NO
3) Do you have difficulty performing detailed work? (sewing, knitting, crocheting, embroidery, bating a fish hook or other fine task)	YES NO
4) Do you have difficulty with personal correspondences? (writing checks, reading bills, filling out forms)	YES NO
5) 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
6) 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

7) Are you unable to see and recognize faces of people? (in church, grocery store, clubs and other daily activities)	YES	NO
8) 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

Patient Signature: _____ Tech Initials: _____