fraserhealth

CATARACT BOOKING CHECKLIST

Patient Surname (legal): _____ **First Name (legal):** _____ **DOB (YYYY-MM-DD):** _____ **PHN:** _____	**Assessment Date:** _____

◯ **BH** ◯ **CGH** ◯ **DH** ◯ **LMH** ◯ **PAH** ◯ **RMH** ◯ **SMH**

Best Corrected Visual Acuity	OD:	OS:

Check **ALL** that apply:

◯ BCVA 20/50 or worse in affected eye, AND

Visual impairment from cataract is responsible for patient's disability in needed/desired activities (e.g. driving, reading, occupational needs)

◯ BCVA 20/40 or better

AND Visual impairment from cataract is responsible for patient's disability in needed/desired activities for the following reasons (please check all that apply):

- ◯ Decreased acuity due to glare or dim lighting
- ◯ Monocular diplopia or polyopia
- ◯ Visual disparity between the eyes

◯ Other indications (please check all that apply)

- ◯ Phacomorphic glaucoma
- ◯ Phacolytic glaucoma
- ◯ Other lens-induced disease
- ◯ Cataract removal required to provide clear ocular media conditions (e.g. diabetic retinopathy)
- ◯ Other: _____

Comments:

Surgeon Name: Signature: