YAG Posterior Capsulotomy Referral Form

Please fax this form to 812.424.3000, Attention Surgery Scheduling

Surgeon: ☐ Dwight A. Silvera, M.D. ☐ Thomas A. Brummer, M.D.

Patient Name: _____ Date of Birth: _____

Please instruct the patient to report to Valley Surgery Center at 220 East Virginia Street, Evansville, IN 47711 for the procedure. Women should not wear eye makeup and all patients should have someone to drive them home after the procedure.

Patient evaluation is completed. I request a YAG Posterior Capsulotomy based on the following clinical findings and patient complaints:

* Patient's vision must be 20/40 or worse BVA or with glare testing, unless the view of the fundus is impeded. Patient complaints must also be noted below to meet the YAG PC medical necessity.

(Circle one) OD OS OU

EYE	BVA	Glare Testing OR	Consensual Light Test	IOP
OD	20 / _____	20 / ____ (line reduction)	20 /	mmHg
OS	20 / _____	20 / ____ (line reduction)	20 /	mmHg

Patient Complaint(s):

- ☐ Difficulty reading small print
- ☐ Difficulty driving in bright light
- ☐ Difficulty driving at night
- ☐ Difficulty reading traffic signs
- ☐ Difficulty writing checks, cards
- ☐ Difficulty watching TV
- ☐ Difficulty with glare / light sensitivity
- ☐ Difficulty with doing hobbies (i.e. sewing, golf, etc.)

☐ Other complaints: _____

_____

Additional Clinical Findings:

_____

_____

Doctor's Signature: _____ Date _____

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