

YAG Posterior Capsulotomy Referral Form

Talley Medical-Surgical Eye Care Associates

Fax to Surgery Scheduling at (812) 424-3000

Referring Doctor: _____, O.D. Date: _____

Surgeon: Terry Talley, M.D. Thomas Brummer, M.D.

Patient: _____ D.O.B.: _____

Patient reports to Valley Surgery for the procedure. Women should wear no eye make-up 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 20/50 or worse BVA or with glare testing unless view of the fundus is impeded. Patient complaints must also be noted below to meet 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's Complaint (s): *(please check all that apply)*

- | | |
|---|---|
| <input type="checkbox"/> Difficulty reading small print | <input type="checkbox"/> Difficulty writing checks, cards |
| <input type="checkbox"/> Difficulty driving in bright light | <input type="checkbox"/> Difficulty watching TV |
| <input type="checkbox"/> Difficulty driving at night | <input type="checkbox"/> Difficulty with glare/light sensitivity |
| <input type="checkbox"/> Difficulty reading traffic signs | <input type="checkbox"/> Difficulty doing hobbies (i.e. sewing, golf, etc.) |
| <input type="checkbox"/> Other Complaints: _____ | |

Additional Clinic Findings:

Doctor's Signature: _____ O.D.