



YAG Posterior Capsulotomy Referral Form

Please fax this form to 812.424.2020, Attention Surgery Scheduling

Surgeon: ☐ Thomas A. Brummer, MD ☐ Karishma A. Habbu, MD ☐ Dwight A. Silvera, MD

Patient Name: _____ Date of Birth: _____

Please instruct the patient to report to Valley Surgery Center at 6201 East Virginia Street, Evansville, IN 47715 for the procedure. Please instruct patients not to wear makeup and that they 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 / _____	_____ mm Hg
OS	20 / _____	20 / _____ (line reduction)		20 / _____	_____ mm Hg

Patient complaint(s):

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

☐ Other complaints:

Additional clinical findings:

Doctor's Signature: _____

Date: _____