CONSTITUTION SURGERY CENTER EAST, LLC

PATIENT SCHEDULING FORM LENS:

PATIENT'S NAME: SS#

Please print clearly
First Name Last Name

DATE OF BIRTH: AGE GENDER: MALE FEMALE

ADDRESS:

PHONE: HOME WORK CELL PHONE

PHYSICIAN: HEIGHT WEIGHT **BMI**

DATE OF SURGERY: LATEX ALLERY: Yes ( ) No ( ) MRSA: Yes ( ) No ( )

ICD: Yes ( ) No ( ) *If yes – need cardio clearance* SHUGARCAINE: Yes ( ) No ( )

DIABETIC: INSULIN Yes ( ) No ( ) ORAL DIABETIC MEDICATIONS Yes ( ) No ( ) INR Yes ( ) No ( )

VAN SERVICE: Yes ( ) No ( ) WHEEL CHAIR VAN: Yes ( ) No ( )

MEDICATION REQUIRED: MITOMYCIN Yes ( ) No ( ) ICGREEN/TRIPAN BLUE Yes ( ) No ( )

MEDICAL PHYSICIAN: OTHER SPECIALIST:

PHONE # PHONE #

MEDICAL CLEARANCE Yes ( ) No ( ) Date if Yes _____

PLEASE CIRCLE CORRECT EYE AND PROCEDURE WITH CODE

PROCEDURE: RIGHT LEFT BILATERAL **ANESTHESIA**: GENERAL BLOCK TOPICAL

66984-Cataract Removal with IOL implant 66821- Yag Laser Capsulotomy 66761-Yag P.I. Laser 65855-SLT Laser

66170-Trabeculectomy 65420-Ptergium 67005-Vitrectomy 67917-Ectropion 67924-Entropion

SECONDARY PROCEDURE _____ CODE _____ **EST TIME** _____

OTHER _____ CODE _____

PLEASE CIRCLE CORRECT DIAGNOSIS CODE DIAGNOSIS CODES:

366.10 366.14 366.15 366.16 366.17 366.53 366.11 362.01 250.51 365.11

OTHER: #1 _____ #2 _____ #3 _____

INSURANCE #1: ID#

Please Note: Any insurance that you are not sure whether or not CESC, EAST is a participant of please fax us a card or call us and we will check to be sure the surgery can be performed in our facility.

INSURANCE #2: ID#

CESCE accepts any insurance as a secondary

INSURANCE PRE-AUTHORIZATION # _____

CONTACT PERSON:

PHONE NUMBER: HOME WORK

SPECIAL NOTES/INFORMATION THAT MAY ASSIST CESCE IN PROVIDING NECESSARY SERVICE TO OUR PATIENTS:
i.e. POA or Conservator

CONSTITUTION EYE SURGERY CENTER
EYE HISTORY AND PHYSICAL

PATIENT:	DATE OF SURGERY:

THIS PATIENT IS BEING ADMITTED TO CESC FOR ELECTIVE CATARACT SURGERY WITH INTRAOCULAR LENS IMPLANT. THE RISKS AND BENEFITS OF THE PROCEDURE HAVE BEEN DISCUSSED AND CONSENT HAS BEEN SIGNED.

THE INDICATION FOR SURGERY IS AS FOLLOWS:

____ BLURRED FOR DISTANCE: DRIVING, TV, OUTDOOR ACTIVITIES, SHOPPING, RECOGNIZING FACES	
____ BLURRED FOR NEAR: READING, COMPUTER WORK, PASTIMES	
____ DISABLING GLARE IN SUNLIGHT OR NIGHT DRIVING	
____ DISCOMFORT DUE TO ANISOMETROPIA	____ PRESENCE OF LENS INDUCED OCULAR DISEASE
____ INABILITY TO PASS DRIVER'S TEST	____ PRESENCE OF CATARACT PRECLUDES DX OR TX OF OTHER OCULAR DISEASE
____ DECREASED DEPTH PERCEPTION	
____ CAN NOT PERFORM WORK DUTIES	____ OTHER

PREVIOUS OCULAR SURGERY:

MOST RECENT EXAM FINDINGS:	R	L
BEST CORRECTED DISTANCE VISION		
BEST CORRECTED NEAR VISION		
APPLANATION TENSION		
PAM		
GLARE DISABILITY		

IOL	TYPE	POWER

INCISION LOCATION:
SUPERIOR
TEMPORAL
OTHER

FINDINGS ON THE SURGICAL EYE R L

CORNEA:

____ CLEAR	____ GUTTATA	____ SCAR	____ OTHER

CATARACT:

____ NUCLEAR SCLEROSIS	____ CORTICAL OPACITY	____ PSC	____ OTHER

FUNDUS:

____ ABLE TO VIEW	____ NO VIEW	____ GLAUCOMATOUS CUPPING	____ OTHER
____ NORMAL DISC	____ SAUCERIZED DISC	____ MACULAR DEGENERATION	____ OTHER
____ NO GROSS MACULAR PATHOLOGY	____ AGE RELATED MACULAR CHANGES		

COEXISTENT:

____ GLAUCOMA	____ DIABETES	____ OTHER	____ NONE

ADDITIONAL COMMENTS:

AXIAL LENGTH:	SPECULAR MICROSCOPY:

SIGNATURE: Date

CONSTITUTION SURGERY CENTER EAST
MEDICAL HISTORY AND PHYSICAL FORM

Patient Name	DOB
Date of Exam	Date of Surgery
Pre-operative Diagnosis	
Chief Complaint	
Allergies ☐ None List	
Current Medications with Dosages	
Anticoagulant ☐ No ☐ Yes	

Assessment	Physical	History
Cardiovascular	☐ WNL	☐ Hypertension ☐ History of MI ☐ Coronary Artery Disease ☐ CHF ☐ Pacemaker ☐ Heart Surgery ☐ AICD ☐ Arrhythmia ☐ Dyslipidemia ☐ Other/Findings
Respiratory	☐ WNL	☐ Sleep Apnea ☐ Asthma ☐ COPD ☐ Other/Findings
CNS	☐ WNL	☐ Seizure Disorder ☐ Dementia ☐ H/O Stroke (CVA/TIA) ☐ Other/Findings
Endocrine	☐ WNL	☐ Diabetes ☐ Insulin ☐ Hypothyroidism ☐ Other/Findings
Gastrointestinal	☐ WNL	☐ GERD ☐ Other/Findings
Musculoskeletal	☐ WNL	☐ Arthritis ☐ Weakness ☐ W/C Bound ☐ Other/Findings
Renal	☐ WNL	☐ Other/Findings
MRSA/VRE	☐ Active	☐ Not Active

Additional Significant Findings

Clearance for Surgery as proposed ☐ Yes ☐ No

Date	**MD Signature**
Time	**MD Print Name**