

Patient Name: \_\_\_\_\_ Practice: Virginia Eye Center, PC

Date: \_\_\_\_\_

**Pre-Cataract Surgery – Visual Functioning Index (VF-8R) Patient Questionnaire**

Do you have difficulty, even with glasses, with the following activities? Please answer for each eye.

	<b>Right Eye</b>	<b>Left Eye</b>
<b>1. Reading small print such as labels on medicine bottles, a telephone book or food labels?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount
	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
<b>2. Reading a newspaper or book?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount
	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
<b>3. Seeing steps, stairs or curbs?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount
	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
<b>4. Reading traffic signs, street signs or store signs?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount
	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
<b>5. Doing fine handwork like sewing, knitting, crocheting or carpentry?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount
	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
<b>6. Writing checks or filling out forms?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount	<input type="checkbox"/> A little <input type="checkbox"/> A moderate amount
	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	<input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity



## CONSENT-WAIVER FOR CORNEAL TOPOGRAPHY TESTING

Your doctor utilizes the most current, up-to-date technology for gathering information which assists in providing you with the very best medical care for your vision. The corneal topography test will provide valuable information to more accurately calculate the correction and amount of correction you may require for your upcoming cataract surgery, including determining if you are a viable candidate for an astigmatism correcting or multifocal advanced technology lens. Because not all insurance companies cover the cost of this test and consider it a non-covered service, if performed, you may be financially responsible. We do not expect that your insurance company will cover the cost of this test.

### Test Fees:

The cost for the corneal topography test (CPT 92025) is \$85.00.

### Beneficiary Agreement

In signing, I understand that my physician has recommended a non-covered, optional service. The fees associated with the corneal topography test have been explained and I understand that I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with this non-covered medical service which is \$85.00.

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Patient Signature (or person authorized to sign for patient)

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Printed Name

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Date

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Have you worn contact lenses in the past 6 months?

YES \_\_\_\_\_ NO \_\_\_\_\_

If **yes**, are they soft contacts or RGP lenses?

Soft \_\_\_\_\_ RGP \_\_\_\_\_

When was the last time you wore your contacts? \_\_\_\_\_

Have you had any corneal surgery? YES \_\_\_\_\_ NO \_\_\_\_\_

If **yes**, what type of surgery? (Circle One) PRK / Lasik / RK / Other \_\_\_\_\_

If **yes**, when and where did you have the surgery?

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<u>OFFICE USE ONLY:</u>
LASIK/PRK/PRK/RK/CK _____
CONTACTS _____
RGP _____

## Please read the following and sign below

If you wear **soft contact lenses**, you will need to stop wearing your lenses prior to your measurement appointment.

- 5 days for standard soft contact lenses
- 14 days for astigmatism correcting soft contact lenses.

If you wear **RGP lenses**, you will need to stop wearing your lenses for several months prior to your surgery. You will also come into the office several times during this period for measurements of your cornea.

**I understand that failure to comply with these instructions will compromise the success of my visual outcome from cataract surgery.**

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_