RESTORATIONEYECARE
TIMOTHY McGARITY, M.D.

Cataract Evaluation

Please fax this completed exam form or your own form to 573-441-2288
or call 573-441-7070 to schedule your patient.

Patient's Name:_____ D.O.B._____

Co-Managing Doctor:_____

CC:_____

(___) Patient complains of significant glare or visual disability which interferes with their Activities of Daily Living.

VA (SC):	**VA (CC)**:	**Glare**:
OD:_____	OD:_____	OD:_____
OS:_____	OS:_____	OS:_____

Current Spectacle Rx:
OD:_____
OS:_____

Refraction:

			ADD	
OD:_____	VA:_____		_____	NVA:_____
OS:_____	VA:_____		_____	NVA:_____

IOP: OD _____ OS:_____ mm Hg @ _____am/pm

Slit Lamp Exam: (Print + or - and comment where applicable)

OD:		OS:
_____	Cornea	_____
_____	AC	_____
_____	Lens	_____
Flat_____ CSME_____ ARMD_____ Other_____	Macula	Flat_____ CSME_____ ARMD_____ Other_____
Intact/Attached_____ Other_____	Peripheral Retina	Intact/Attached_____ Other_____
Other _____	Other	Other_____

Impression: (___) Visually Significant Cataract: OD, OS or OU
(___) Other:_____

Plan: (____) Recommended Cataract Surgery Evaluation with Dr. McGarity.
(____) Recommended Advanced Preop Testing Options for Refractive Outcome
(____) Recommended Toric Lens to address significant Astigmatism
(____) Recommended Multifocal Lens or Blended Monovision to address Presbyopia
(____) Other: _____

_____ _____
Optometric Physician's Signature Date

For emergency contact office 573-441-7070 Dr. McGarity's cell 573-268-7478 or Hospital 573-882-4141