EYE CONSULTANTS
OF TEXAS

YAG LASER SCHEDULING

While the referring optometrist is not required to complete the YAG Capsulotomy Day of Surgery Approval Form, it would be helpful if this written information was included in your exam notes that are provided to Eye Consultants of Texas (ECT)/ Lonestar Ambulatory Surgery Center (LSASC) prior to YAG Laser Treatment. This will reduce the amount of additional testing needed, as well as reduce the amount of time your patient is at ECT/LSASC. We suggest adopting the following guidelines and have included a template for your convenience:

- **Activity of Daily Living (ADL)**
  - In order for the procedure to be deemed medically necessary, there must be an ADL impacted. Please document, in the patient's own words, how their daily life has been affected.
- **Posterior Capsular Opacity (PCO)**
  - Please remember to document the grade of the PCO in the exam note (usually graded between 1 and 4).
    - Example: 2+ PCO
- **Specify Eye**
  - Please remember to document in the exam note which eye requires YAG laser treatment. If both eyes need treatment, please indicate which eye you and the patient would like to have done first (this is a Medicare/Insurance requirement).
- **Glare/BAT**
  - A glare test **IS needed** if the Best Corrected Visual Acuity (BCVA) is better than 20/40 (20/15, 20/20, 20/25, 20/30).
    - Example:

BSCVA	Refraction	Glare
20/25	+1.00 -1.50x180	20/40

  - If BCVA is 20/40 or worse, glare testing is **NOT needed.**
  - If you are unable to perform glare testing at your office, we will be happy to perform it at ECT. Please indicate in your exam note that you would like us to perform the glare test and we can do it before the procedure.

Please remember also that the time your patient spends at Eye Consultants of Texas may be prolonged if any of the aforementioned steps are omitted at your office.

If you have any questions, please call our Direct Physician Phone Line at **(817) 416-7907** to speak with a technician or doctor. Please fax your exam notes to our office at **(817) 251-6261** for our records. You may also email us at **comgmt@eyecontx.com**

EYE CONSULTANTS
OF TEXAS

1ST EYE YAG CAPSULOTOMY DAY OF SURGERY APPROVAL FORM

Patient: _____ **DOB:** _____ **Date:** _____

Referring OD/MD/DO: Dr. _____ **Last Eye Exam Date:** _____

Chief Complaint: _____

HPI *(including length of time, activities affected, which eye, severity, and ADL affected):* _____

_____

_____

	BCVA	Refraction	Glare	IOP
OD				
OS				

Slit Lamp / Direct Ophthalmoscope Exam	OD WNL	OD Findings	OS WNL	OS Findings
Lids / Adnexa				
Conjunctiva				
Cornea				
Anterior Chamber				
Iris				
Lens / Capsule				
Fundus Exam	**OD WNL**	**OD Findings**	**OS WNL**	**OS Findings**
Optic Nerve & Cup to Disc Ratio				
Vitreous				
M/V/P				

☐ I have reviewed and agree with the above except as otherwise noted: _____.

Assessment:

1. Visually Significant PCO OD / OS with significant lifestyle impairment.

Plan:

1. Offer YAG Capsulotomy OD / OS. Risks and benefits explained. Patient understands, has had all questions answered satisfactorily, and wishes to proceed with surgery.

Phillips Kirk Labor, MD Date

EYE CONSULTANTS
OF TEXAS

2ND EYE YAG CAPSULOTOMY DAY OF SURGERY APPROVAL FORM

Patient: _____ **DOB:** _____ **Date:** _____

Referring OD/MD/DO: Dr. _____ **Last Eye Exam Date:** _____

Chief Complaint: _____

HPI *(including length of time, activities affected, which eye, severity, and ADL affected):* _____

_____

_____

	UCDVA	UCIVA	UCNVA	Refraction	BCDVA	Glare/BAT	IOP
OD							
OS							
OU							

Slit Lamp / Direct Ophthalmoscope Exam	OD WNL	OD Findings	OS WNL	OS Findings
Lids / Adnexa				
Conjunctiva				
Cornea				
Anterior Chamber				
Iris				
Lens / Capsule				
Fundus Exam	**OD WNL**	**OD Findings**	**OS WNL**	**OS Findings**
Optic Nerve & Cup to Disc Ratio				
Vitreous				
M/V/P				

☐ I have reviewed and agree with the above except as otherwise noted: _____.

Assessment:

1. Visually Significant PCO OD / OS with significant lifestyle impairment.

Plan:

1. Offer YAG Capsulotomy OD / OS. Risks and benefits explained. Patient understands, has had all questions answered satisfactorily, and wishes to proceed with surgery.

Phillips Kirk Labor, MD Date

EYE CONSULTANTS
OF TEXAS

CO-MANAGEMENT TRANSFER OF CARE FORM: LASERS

Date: _____

Co-Management Provider: Dr. _____ **Fax:** _____

Patient Name: _____ **DOB:** _____

Phone: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Date of Surgery: _____ **Date your Postoperative Care Begins:** _____

Procedure/Lens: _____

Diagnosis Code: _____ **CPT Code:** _____

☐ **Premium IOL** ☐ **Standard IOL** **Global End:** _____

Post-Op Uncorrected VA: _____ **IOP:** _____

Notes: _____

_____

Post-Operative Medications

OD:	**OS:**
[ ] Prednisolone QID	[ ] Prednisolone QID
[ ] Other:	[ ] Other:

Surgeon Name: Phillips K. Labor, M.D.

Surgeon Signature: _____ **Date:** _____