

Yag Capsulotomy Co-Management Form

Fax #: _____

Date Faxed: _____

IMPORTANT BILLING INFORMATION BELOW

D.O.B: _____

Co-managing Doctor _____ Date Discharged for Post-op Care _____

Patient Name _____ St. Luke's Chart # _____

Surgeon: Kimberly Ireland, MD Joseph Licht, DO John Gooch, MD

RE	Preoperative Findings	LE
LENS <input type="checkbox"/> PCO	LENS <input type="checkbox"/> PCO	LENS <input type="checkbox"/> PCO
Fundus _____	Fundus _____	Fundus _____
C/D _____	C/D _____	C/D _____

Surgery	
Date of Procedure _____	Date of Procedure _____
<input type="checkbox"/> YAG Cap	<input type="checkbox"/> YAG Cap

Postoperative Evaluation			
Co-Managing Doctor to Complete at Post-op Check			
Date of Post Op _____	Date of Post Op _____	Date of Post Op _____	Date of Post Op _____
VA sc _____/_____	VA sc _____/_____	VA sc _____/_____	VA sc _____/_____
Refraction _____ IOP _____	Refraction _____ IOP _____	Refraction _____ IOP _____	Refraction _____ IOP _____
Lens <input type="checkbox"/> IOL Well Centered <input type="checkbox"/> _____	<input type="checkbox"/> IOL Well Centered <input type="checkbox"/> _____	<input type="checkbox"/> IOL Well Centered <input type="checkbox"/> _____	<input type="checkbox"/> IOL Well Centered <input type="checkbox"/> _____
<input type="checkbox"/> Good Capsular Opening <input type="checkbox"/> _____	<input type="checkbox"/> Good Capsular Opening <input type="checkbox"/> _____	<input type="checkbox"/> Good Capsular Opening <input type="checkbox"/> _____	<input type="checkbox"/> Good Capsular Opening <input type="checkbox"/> _____

Medication	Insurance
<input type="checkbox"/> 1gtt of Pred PO _____ _____ _____	<div style="display: flex; justify-content: space-around;"> Medicare Commercial </div> _____ _____

Your office is responsible to bill Medicare patients. We will send a co-management check if the patient has a commercial insurance.

Authorized Signature _____