CATARACT SURGERY REFERRAL CHECKLIST

DOS REQUESTED :_____/_______/__________

PATIENT LEGAL NAME:____
PATIENT ALTERNATE/PREFERRED NAME:____
PATIENT DOB:_____/_______/_____________
NUMBER OF PAGES ATTACHED: ____________
DOES THIS SERVICE REQUIRE AUTH? Y/N (If so, please attach a copy of the auth letter)
AUTH #:____

✔	THE FOLLOWING ITEMS MUST BE INCLUDED IN THIS PACKET:
	BOOKING SHEET (INCLUDING CPTS AND ICD-10 DX CODES)
	DEMOGRAPHICS (INCLUDING LEGIBLE PATIENT'S LEGAL IDENTIFICATION AND INSURANCE CARD)
	INSURANCE AUTH # AND APPROVAL LETTER
	OFFICE NOTES FROM REFERRING PROVIDER (ALL PREVIOUS VISUAL FIELD EXAMS, TRIALS, AND TESTING)
	STATEMENT OF IMPAIRMENT OF VISUAL FUNCTIONING & EXPECTATION OF LENS SURGERY
	DEGREE OF LENS OPACITY
	SIGNED H&P (WITHIN 30 DAYS OF SURG OR 24 HRS OF ADM) AND ORDERS (these are not required to be included in booking packet, but we will need them before surgical date)
	IF YOU HAVE ANY CONCERNS WITH THE SCHEDULING OR CLEARANCE PROCESS, IT WOULD HELP TO EXPEDITE THE PROCESS IF YOU INCLUDE A MEDICATION LIST, OR ANY OUTSIDE RECORDS ON A PATIENT (LABS, CARDIAC, NEPHROLOGY, PULMONOLOGY, ETC)

***If any of the above line items do not apply, please mark N/A.

COMMENTS (SMC Internal Use Only)

	Inpatient Only List Reviewed
	Medicare Outpatient Authorization List Reviewed

DATE RECEIVED: _____/_____/__________
DATE REVIEWED: _____/_____/_________
REVIEWER: _________________________

v2 3/7/2023

Please fax completed form to with all required documentation to SMC Scheduling at 307.215.0750