CATARACT SURGERY BOOKING FORM

Surgeon: DR. ATTENDING PHYSICIAN

Patient Name: Sample, Patient Beta

Address: 123 Main St. Apt. 218Dartmouth, NSB2B2B2

Phone number: (902) 555-0248 work, (902) 555-1729 cell,

DOB: 1982/03/14

Male: ☐ Female: ☒

HCN: 0001000009

Priority level

III- 6 weeks ☒	IV-13 weeks ☐

RIGHT EYE ☐

LEFT EYE ☒

Date Referral received by Surgeon: yyyy 2014 mm 06 dd 12

Date first seen by surgeon for this condition: yyyy 2014 mm 07 dd 29

Date of decision for surgery: yyyy 2014 mm 07 dd 29

Patient unavailability: Start date yyyy _____ mm _____ dd _____

Patient unavailability: End date yyyy _____ mm _____ dd _____

To be filled in post op by Utilization

Surgery Date: / /