Elmhurst Outpatient Surgery Center
Catalys Treatment Plan

This form must be completed by the surgeon for each Catalys patient and faxed to **331.221.3929** at least ***three business days*** prior to the day of surgery. Surgeons are also encouraged to bring a visual representation of the eye with arcuate incisions on the day of surgery as another confirmation during the time out process.

Date of Surgery: _____

Surgeon: _____

Patient Name: _____

ID (EOSC to complete): _____

Patient Date of Birth: _____

Treatment Eye: _____

Planned Incisions: ☐ Capsulotomy ☐ Lens Fragmentation ☐ Arcuate Incisions ☐ Cataract Incisions

Capsulotomy

Template Name: ☐ Routine ☐ Custom *(if custom, surgeon must enter parameters)*

Centering Method: ☐ Pupil ☐ Limbus ☐ Scanned Capsule ☐ Custom

Lens Fragmentation

Template Name: ☐ Routine ☐ Custom *(if custom, surgeon must enter parameters)*

Grade: ☐ Grade 1 ☐ Grade 2 ☐ Grade 3 ☐ Grade 4

Arcuate Incisions

Type: ☐ Single ☐ Symmetric ☐ Asymmetric

Axis: _____

Optical Zone: _____

Length: _____

Centering Method: ☐ Pupil ☐ Limbus ☐ Custom

Cataract Incisions

Template Name: ☐ Routine ☐ Custom *(if custom, surgeon must enter parameters)*

For EOSC Use ONLY

Data entered by: _____ **Date:** _____

Data confirmed by: _____ **Date:** _____

Modifications made to incisions on day of surgery? ☐ Yes ☐ No **Circulator Initials:** _____

Physician Signature (if incisions modified): _____