CATARACT SURGERY REGISTRY (CSR):
PRE-CLERKING RECORD

Office use: ____ / ____

Centre ____

Instruction: This form is to be filled for patient who is going to have Cataract Surgery but excluded secondary IOL Implatation. Where check boxes ☐ are provided, check (√) one or more boxes. Where radio buttons ○ are provided, check (√) one box only.

** indicates compulsory field.*

i.) Hospital / Clinic: ____ ii) Date : d d m m y y

SECTION 1 : PATIENT PARTICULARS

*1 Patient Name:

*2 Identification Card Number — My Kad / MyKid: ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ Old I.C: ____

If MyKad/MyKid is not available, please complete the Old Ic or Other ID document No.

Other ID document No: ____ → Specify type (eg. Passport, armed force ID): ____

3. Address: Postcode: ☐☐☐☐☐ Town/ City: ____ State: ____

*4 a. Date of Birth: d d m m y y y y

4b. Age at notification: (in years) or (in months if< 1 yr old ____ ____ Auto Calculated

*5 Gender: ○ Male ○ Female

6. Ethnic Group: ○ Malay ○ Chinese ○ Indian ○ Orang Asli ○ Melanau ○ Kadazan/Murut/Bajau ○ Bidayuh ○ Iban ○ Others, specify:

SECTION 2: MEDICAL HISTORY

(check √ one box as appropriate)

*1. Surgery On:

○ First eye
○ Second eye → Date of first eye surgery: ____
Intra-op complications: ○ Yes ○ No

2. Past Ocular Surgery of the Eye to be operated

☐ None
☐ Vitreoretinal Surgery
☐ Penetrating Keratoplasty
☐ Filtering Surgery
☐ Pterygium Excision
☐ Others, specify: ____

3. Cause of Cataract

○ Primary OR ○ Secondary

a) If primary:
○ Senile/age related
○ Congenital
○ Developmental
○ Others ____

a) If secondary:
○ Trauma
○ Drug Induced
○ Surgery Induced
○ Others ____

*4. Ocular Comorbidity

(check √ one or more boxes below if present)

☐ None

a) ANTERIOR SEGMENT:

☐ Pterygium involving the cornea
☐ Corneal Opacity
☐ Glaucoma
☐ Chronic Uveitis
☐ Pseudoexfoliation

Lens Related Complications
☐ Phacomorphic
☐ Phacolytic
☐ Subluxated/ Dislocated

b) MISCELLANEOUS:

☐ Amblyopia
☐ Significant previous eye trauma
☐ Pre-existing non glaucoma field defect (eg. CVA)

c) POSTERIOR SEGMENT

Diabetic Retinopathy
☐ Non Proliferative Diabetic Retinopathy
☐ Proliferative Diabetic Retinopathy
☐ Maculopathy
☐ Vitreous haemorrhage

☐ ARMD
☐ Other macular disease (includes hole or scar)
☐ Optic nerve disease, any type
☐ Retinal detachment
☐ Cannot be assessed

☐ Other ocular comorbidity, specify: ____

5. Systemic Comorbidity

(check √ one or more boxes below if present)

☐ None
☐ Hypertension
☐ Diabetes Melitus
☐ Ischaemic Heart Disease
☐ Others, specify: ____
☐ Renal Failure
☐ Cerebrovascular accident
☐ COAD/ Asthma

SECTION 3: PREOPERATIVE VISUAL ACUITY MEASUREMENT

(Please fill up at least one of the "presenting visual acuity" or "refracted visual acuity")

Vision	a) Right	b) Left
*1. Unaided:		
2. With glasses/ Pin Hole		
3. Refracted		
4. Refraction		
Sp	○ +	○ +
	○ -	○ -
	○ NA	○ NA
Cy		
Axis		

SECTION 4: BIOMETRY TECHNIQUE & PLANNED REFRACTIVE POWER FOR OPERATED EYE

* 1 Biometry Technique

○ Indentation ○ Immersion ○ Interferometry Laser
○ Others, specify ____ ○ NA

2 Planned Refractive Power ____
○ +
○ -
○ NA

Pre-Clerking Form Version 2.22 last updated on 21/05/2012