



Endophthalmitis Post Cataract Surgery Study

Wilmer Eye Institute at Johns Hopkins Medicine



To the cataract surgeon,

Thank you for agreeing to participate in this important study to help understand the risk factors for endophthalmitis after cataract surgery. Such a study relies completely on the assistance and goodwill of surgeons such as yourself. The following paragraphs provide background and instructions to assist with accurate data collection.

1. Due to privacy issues, only the patient's Medicare Identification Number is made available (and not the patient's name). We understand this will require an extra step for your practice administrator to match this number with the patient's name. We have also provided the Medicare "Date of Claim" to help in this process. The Medicare "Date of Claim" is typically the same as the Medicare "Date of Surgery." However, if this is found not to be the case, please indicate the correct date of surgery on the form. In addition, we have included the patient's date of birth, race, and gender, which may also help you in identifying your patient.
2. After you have identified the patient, and have his/her chart in front of you, please take care in filling out the form. You may require additional information (such as the surgery report or operating room chart) to answer some of the questions accurately. If so, please acquire those materials before completing the form.
3. If you were the surgeon in this case, we request that you, alone, fill out the form. Write as legibly as possible. Provide as much detail as possible. Only answer those questions that you are sure of. If you do not know, or are unsure of an answer, please simply indicate, "Don't know."
4. If, after careful scrutiny, you find that this indeed is not your patient, please check the box beside "This is not my patient".
5. When you are finished, please fax all information to 888-681-0979.

Thank you for your assistance. If you would like to be apprised of the study findings, please provide an email address where we can send our final study report:

Sincerely,

Emily W. Gower

Emily Gower, PhD
Principal Investigator

PATIENT INFORMATION

Medicare ID Number: _____ DOB: _____ Race: _____
 Medicare Cataract Surgery Billing Date: _____ Gender: _____

This is not my patient.

Gender is wrong.

SURGEON INFORMATION

1. Provider's Name: _____

2. Cataract Surgery Volume for the Year 2003:

3. Surgical Setting of This Case:

Name: _____ City/State: _____

- 1 Hospital-based Ambulatory Center (ASC)
- 2 Freestanding ASC
- 3 Office-based Operating Room

4. Person completing this form:

- 1 This Patient's Cataract Surgeon
- 2 Another Ophthalmologist
- 3 Optometrist
- 4 Office Manager/Assistant
- 5 Ophthalmic Technician/Nurse
- 6 Other (please specify) _____

5. Contact Information of Practice Administrator/Manager:

Name: _____ Email: _____ Phone# _____
 _____ Fax# _____

ANESTHESIA

17. Local Anesthesia:

- None
 Topical Only
 Topical + intracameral lidocaine
 Subtenons
 Retrobulbar / peribulbar injection with needle
 Other: _____
 Don't Know

ANTIBIOTIC AND STEROID USE Before and During Surgery

18. BEFORE Day of Surgery:

a. Topical antibiotic started several days in advance of cataract surgery?

- No
 Yes → Name: _____
 Number of days: _____
 Don't Know
 Drops per day: _____

19. On Day of Surgery, Pre-operative: (before incision)

a. Topical antibiotic:

- No
 Yes → Name: _____
 Number of Drops: _____
 Don't Know

b. Preoperative antiseptic on ocular surface:

- None
 Povidone Iodine
 Other: _____
 Don't Know

20. During Surgery: (before wound closure)

a. Antibiotics in irrigation solution?

- No
 Yes → Name: _____
 Don't Know

b. Intracameral antibiotic injection?

- No
 Yes → Name: _____
 Don't Know

c. Intracameral steroid injection?

- No
 Yes → Name: _____
 Don't Know

21. Peri-operative: (in operating room after wound closure)

a. Subconjunctival injection given?

- No
 Yes → Antibiotic Name: _____ Steroid Name: _____
 Don't Know

b. Eye drops given?

- No
 Yes →
 Yes, with Collagen Shield
 Don't Know
- | | Name: | | Type (Please Check One): |
|----|-------|---|--|
| 1. | | → | <input type="checkbox"/> Antibiotic <input type="checkbox"/> Non-Steroid
<input type="checkbox"/> Steroid <input type="checkbox"/> Antibiotic+Steroid |
| 2. | | → | <input type="checkbox"/> Antibiotic <input type="checkbox"/> Non-Steroid
<input type="checkbox"/> Steroid <input type="checkbox"/> Antibiotic+Steroid |

c. Ointment given?

- No
 Yes →
 Don't Know
- | | Name: | | Type (Please Check One): |
|----|-------|---|--|
| 1. | | → | <input type="checkbox"/> Antibiotic <input type="checkbox"/> Non-Steroid
<input type="checkbox"/> Steroid <input type="checkbox"/> Antibiotic+Steroid |
| 2. | | → | <input type="checkbox"/> Antibiotic <input type="checkbox"/> Non-Steroid
<input type="checkbox"/> Steroid <input type="checkbox"/> Antibiotic+Steroid |

POST-OPERATIVE REGIMEN

22. Shield?

- 0 No
 1 Yes
 9 Don't Know

23. Patch?

- 0 No
 1 Yes
 9 Don't Know

24. Eye Drops Used:

- 0 No 1 Yes 9 Don't Know

Please complete the chart below for any eye drops used:

	Name:	Type (Please Check One):	# Drops on day of surgery after leaving OR:	# Drops/day:			
				1st Week:	2nd Week:	3rd Week:	4th Week:
1.	→	1 <input type="checkbox"/> Antibiotic 3 <input type="checkbox"/> Non-Steroid 2 <input type="checkbox"/> Steroid 4 <input type="checkbox"/> Antibiotic+Steroid →					
2.	→	1 <input type="checkbox"/> Antibiotic 3 <input type="checkbox"/> Non-Steroid 2 <input type="checkbox"/> Steroid 4 <input type="checkbox"/> Antibiotic+Steroid →					

25. Ointments Used:

- 0 No 1 Yes 9 Don't Know

Please complete the chart below for any ointments used:

	Name:	Type (Please Check One):	# Doses on day of surgery after leaving OR:	# Doses/day:			
				1st Week:	2nd Week:	3rd Week:	4th Week:
1.	→	1 <input type="checkbox"/> Antibiotic 3 <input type="checkbox"/> Non-Steroid 2 <input type="checkbox"/> Steroid 4 <input type="checkbox"/> Antibiotic+Steroid →					
2.	→	1 <input type="checkbox"/> Antibiotic 3 <input type="checkbox"/> Non-Steroid 2 <input type="checkbox"/> Steroid 4 <input type="checkbox"/> Antibiotic+Steroid →					

26. Oral Antibiotic:

- 0 No 1 Yes 9 Don't Know

Please complete the chart below for any medications prescribed:

	Name:	Dose:	Duration:
1.	→	→	→
2.	→	→	→

27. Did patient develop endophthalmitis?

- 0 No
 1 Yes
 9 Don't Know

a. Name of Retinal Specialist: _____

b. Contact Information: _____

c. Final Diagnosis:

- 1 Culture Positive
 2 Culture Negative
 3 TASS (Toxic Anterior Segment Syndrome)
 9 Don't Know