



Endophthalmitis Post Cataract Surgery Study

Wilmer Eye Institute at Johns Hopkins Medicine



To the retinal 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 doctors 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 Service." However, if this is found not to be the case, please indicate the correct date of service 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. If you were the ophthalmologist 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."
3. If, after careful scrutiny, you find that this indeed is not your patient, please check the box beside "This is not my patient".
4. 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 Gower, PhD
Principal Investigator

Endophthalmitis is defined as:

1. Pain and/or decreased vision
... AND ...
2. Hypopyon or vitritis within 6 weeks following cataract surgery.

PATIENT INFORMATION		
Medicare ID Number: _____	Medicare Billing Dates: _____	DOB: _____
	Cataract Surgery: _____	Race: _____
	Endophthalmitis Claim: _____	Gender: _____

This is not my patient.

Gender is wrong

OPHTHALMOLOGIST INFORMATION
1. Provider's Name: _____
2. Person completing this form:
1 <input type="checkbox"/> This Patient's Retinal Specialist
2 <input type="checkbox"/> Another Ophthalmologist
3 <input type="checkbox"/> Optometrist
4 <input type="checkbox"/> Office Manager/Assistant
5 <input type="checkbox"/> Ophthalmic Technician/Nurse
6 <input type="checkbox"/> Other (please specify) _____
3. Contact Information of Practice Administrator/Manager:
Name: _____ Phone# _____
Email: _____ Fax# _____

4. Date of first visit:

mm / dd / yy

Don't Know

5. Date of Onset of Symptoms:

mm / dd / yy

Don't Know

Do not complete rest of form. Please return this form as well as the patient's chart.

6. Clinical Findings on Presentation:

- 1 No Endophthalmitis: STOP
- 2 Presumed endophthalmitis in:
- 9 Don't Know

Endophthalmitis Where?

- 1 Right eye
- 2 Left eye
- 9 Don't Know

7. Please Indicate if the Following Conditions Apply:

- | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|--|
| a. Wound Leak | b. Hypopyon | c. Vitritis | d. 4+ cell and flare in anterior chamber |
| 0 <input type="checkbox"/> No | 0 <input type="checkbox"/> No | 0 <input type="checkbox"/> No | 0 <input type="checkbox"/> No |
| 1 <input type="checkbox"/> Yes | 1 <input type="checkbox"/> Yes | 1 <input type="checkbox"/> Yes | 1 <input type="checkbox"/> Yes |
| 9 <input type="checkbox"/> Don't Know | 9 <input type="checkbox"/> Don't Know | 9 <input type="checkbox"/> Don't Know | 9 <input type="checkbox"/> Don't Know |

8. Presenting VA in Affected Eye (corrected or pinhole):

- | | | | | |
|---------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|---|
| 0 <input type="checkbox"/> Don't Know | 3 <input type="checkbox"/> HM | 6 <input type="checkbox"/> 20 / 200 | 9 <input type="checkbox"/> 20 / 60 | 12 <input type="checkbox"/> 20 / 30 |
| 1 <input type="checkbox"/> NLP | 4 <input type="checkbox"/> CF | 7 <input type="checkbox"/> 20 / 100 | 10 <input type="checkbox"/> 20 / 50 | 13 <input type="checkbox"/> 20 / 25 |
| 2 <input type="checkbox"/> LP | 5 <input type="checkbox"/> 20 / 400 | 8 <input type="checkbox"/> 20 / 80 | 11 <input type="checkbox"/> 20 / 40 | 14 <input type="checkbox"/> 20 / 20 or better |

9. Please Check All Procedures Performed:

a. Vitreous Tap

- 0 No
 - 1 Yes → Date: mm / dd / yy
 - 9 Don't Know
- Don't Know Date

b. Intravitreal Antibiotic Injection

- 0 No
 - 1 Yes → Date: mm / dd / yy
 - 9 Don't Know
- Don't Know Date

Intravitreal Antibiotic Injection(s)

- 1. Name: _____
Dose: _____ Total # Injections: _____
- 2. Name: _____
Dose: _____ Total # Injections: _____
- 3. Name: _____
Dose: _____ Total # Injections: _____

c. Vitrectomy

- 0 No
 - 1 Yes → Date: mm / dd / yy
 - 9 Don't Know
- Don't Know Date

d. Other Surgical Procedures:

Name of Procedure: _____ Date: mm / dd / yy Don't Know Date

Name of Procedure: _____ Date: mm / dd / yy Don't Know Date

10. Systemic Antibiotics Given For Endophthalmitis?

- 0 No
- 1 Yes →
- 9 Don't Know

Systemic Antibiotics:

1. Name: _____
Route: _____

2. Name: _____
Route: _____

3. Name: _____
Route: _____

11. Vitreous Culture Results:

- 0 Culture not taken
- 1 Culture negative
- 2 Culture Taken, Results Not Known
- 3 Culture Positive, Organism Not Known →
- 4 Culture positive, organisms: →
- 9 Don't Know

0 Gram + 1 Gram - 9 Don't Know

Organisms:

1. _____ 3. _____
2. _____ 4. _____

12. VA (corrected or pinhole) In Affected Eye At Last Follow-up Visit For This Problem:

- | | | | | |
|---------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|---|
| 0 <input type="checkbox"/> Don't Know | 3 <input type="checkbox"/> HM | 6 <input type="checkbox"/> 20 / 200 | 9 <input type="checkbox"/> 20 / 60 | 12 <input type="checkbox"/> 20 / 30 |
| 1 <input type="checkbox"/> NLP | 4 <input type="checkbox"/> CF | 7 <input type="checkbox"/> 20 / 100 | 10 <input type="checkbox"/> 20 / 50 | 13 <input type="checkbox"/> 20 / 25 |
| 2 <input type="checkbox"/> LP | 5 <input type="checkbox"/> 20 / 400 | 8 <input type="checkbox"/> 20 / 80 | 11 <input type="checkbox"/> 20 / 40 | 14 <input type="checkbox"/> 20 / 20 or better |

13. Date of VA In Affected Eye At Last Follow-up Visit For This Problem:

Don't Know

____ / ____ / ____
mm dd yy

14. Final Diagnosis:

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

15. If you don't have follow-up information on this patient, please indicate who does:

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