95-717 Kipapa Drive #23
Mililani, Hawai`i 96789
(808) 536-3961
contact@hawaiianeyefoundation.org
**www.hawaiianeyefoundation.org**

HAWAIIAN EYE FOUNDATION

# CATARACT DAYS SCREENING FORM

Name: _____
First Middle Initial Last

Date of Birth: _____ Phone Number: _____
*month/day/year* *(area code)* _ _ _ - _ _ _ _

Address: _____

Email: _____

Have you been told that you have a cataract? *(circle your answer)*
YES or NO

Do you have medical insurance of any kind? *(circle your answer)*
YES or NO

If yes, what type of insurance do you have? _____

*Appointment dates are March 11th, March 20th and March 21st. All will be held at the Hawaiian Eye Center in Wahiawa.*

Will you attend all mandatory appointments? (circle your answer)
YES or NO

Do you need a ride to and from appointments? (circle your answer)
YES or NO

If applicable,
Case Worker's Name: _____

Case Worker's Contact Info: _____

PLEASE RETURN THIS FORM TO DARRAH@HAWAIIANEYEFOUNDATION.ORG OR CALL (808)536-3961 BY MARCH 6, 2017. CONTACT US WITH ANY QUESTIONS.