**Cataract Referral Form**

|  |  |
| --- | --- |
| **Patient’s preferred provider:** |  |
| **Section 1: Assessment information** |  |  |
| **Patient’s Details** | **Sight test date:** |  |
| *First name:* | **Date of referral:** |  |
| *Last name:* | **Optometrist / Practice** |
| *DOB:* | *Optometrist:* |
| *NHS number:* | *Practice:* |
| *Address:* |
| *Phone:* |
| **Patient’s GP** |
| *GP name:* |
| *Phone:* | *Practice:* |
| *Mobile:* |
| *Email:* |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current Refraction** |  | **Sph** | **Cyl** | **Axis** | **Prism** | **Base** | **VA** | **Add** | **N VA** | **IOP(mmHg)** | **IOP****METHOD** | **Date** |
|  |
| **R** |  |  |  |  |  |  |  |  |  |  |  |
| **L** |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Previous Refraction** |  | **Sph** | **Cyl** | **Axis** | **Prism** | **Base** | **VA** | **Add** | **N VA** | **Date** |
|  |
| **R** |  |  |  |  |  |  |  |  |  |
| **L** |  |  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **RE** | **LE** |
| **Significant AMD?** |  |  |
|  |  |
|  |  |
| **Diabetic retinopathy?** |  |  |
|  |  |
| **Inadequate fundal view?** |  |  |
|  |  |
| **Under treatment for glaucoma?** |  |  |
|  |  |
| **Amblyopia?** |  |  |
|  |  |
| **Any corneal abnormalities?** |  |  |
|  |  |
| **Blepharitis?** |  |  |
|  |  |
| **Cataract?** |  |  |
|  |  |
| **Preferred eye for surgery?** |  |  |
|  |  |
| **Previous cataract operation?** |  |  |
|  |  |
| **Previous refractive surgery?** |  |  |
|  |  |
| **Date of assessment** |  |  |
|  |

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| ***Patient dilated?*** |  |  |
|  |
| ***Patient’s vision 6/9 or better?*** |  |  |
| *If yes, please complete section 2 below* |
| ***Any other ocular pathology or notes*** |  |  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Px has visual difficulties due to cataracts?** |  |  | ***Px wants cataract surgery at this time?*** |  |
| **Benefits and risks of surgery explained?** |  | ***Px consented to information sharing?*** |  |

**Section 2: EUR policy compliance**

|  |  |
| --- | --- |
| **YES** | **NO** |
| Does the patient have a concomitant ocular disease where functional improvement is unlikely? |  |  |
|  |  |  |
| Patient reports excessive difficulty in twilight or dark conditions? |  |  |
|  If yes, has the difficulty been confirmed by a clinician to be the result of reduced contrast sensitivity? |
| Is the patient reporting difficulties with any of the following: |  |  |
| * Difficulty carrying out everyday tasks such as recognising faces, watching TV, reading, cooking, playing sport/cards etc.
 |  |  |
| * Reduced mobility, experiencing difficulties in driving, for example, due to glare, or experiencing difficulty with steps or uneven ground.
 |  |  |
| * Ability to work, give care or live independently is affected
 |  |  |

**If referral is for 2nd eye:**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| Are there binocular considerations? |  |  |  |
| Is there anisometropia (a significant difference in refractive error between the two eyes of more than 1.00DD in any meridian)? |  |  |  |
| Is there a disabling glare? |  |  |  |

*Additional comments:*

*Referral form to be sent to the nominated surgical provider* ***direct*** *(from a secure nhs.net account)*

 *MREH -Withington hospita: l* *Mft.wch.admin@nhs.net*

 *Optegra : Fax: 0207 022 1651 Tel: 0207 509 4186*

 *Spa Medica : Fax 0161 8351704 Tel: 0161 838 0870*