Referral Copy (4)

Cataract Direct Referral Form

Section 1 to be completed by Optometrist

		Accreditation No.
Patient's Mr / Mrs Name	GP's Name	Optometrist's Name
Date of Birth Address Postcode	Address Postcode	Address Postcode Fax No:
Tel No:	Tel No:	Tel No:

Ethnicity: ....

Original Referral done by: Self ❑ GP or other optometrist ❑

NHS No. (if available)

❑ Yes ❑ No I have explained the benefits and risks
❑ Yes ❑ No The patient wants cataract surgery under local anaesthetic
❑ Yes ❑ No The patient has red reflex
❑ Yes ❑ No The patient has significantly impaired visual function
❑ Yes ❑ No The patient dilates well

Hospital chosen by Patient:

		Sph	Cyl	Axis	Prism	Add	VA	Near	IOP AT / NCT
Previous refraction	R								mm/Hg
Date:	L								mm/Hg
Current refraction	R								mm/Hg
Date:	L								mm/Hg

Lens R Clear Nuc Cor PSC

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Cornea R ❑ Healthy ❑ L
Macula R ❑ Healthy ❑ L ARMD mild / moderate / severe
Discs R ❑ Healthy ❑ L Diabetic maculopathy mild / moderate / severe
Pupils dilated Size.......... mm
Squint / Amblyopia / Other Comment ....

Other medical conditions..

PMH Diabetes ❑ Hypertension ❑ Heart Dis ❑ Respiratory Dis ❑ CNS Dis ❑
Drugs Warfarin ❑ Steroids ❑ Aspirin ❑
Comments..
Social *Driver* ❑ *Special visual needs* ❑
Comments ....

Signature of Accredited Optometrist

Signed ....

I agree / do not agree that any Ophthalmologist to whom I am referred for medical consultation and / or treatment may make information relevant to my eye condition and its treatment available to my Optometrist / Ophthalmic Practitioner. I agree / do not agree that my information may also be used for audit purposes.
Signed...**Date**................

Version Oct 2007

Copy 1: Fax/Post to RBMS **Copy 2**: To GP **Copy 3**: Audit/Payment **Copy 4**: Opticians Record