Cataract Referral Refinement (Pre-op)

evolutio ophthalmology

Referral date: ________________ Date of sight test (if different) ________________

Patient Details

Title: ____________ Patient first name: ____________________ Patient surname: ____________________

DOB: ____________

Address: ____

Postcode: ____________

Telephone: ________________________ NHS Number: ____________________

Clinician Details

Referring clinician name: ______________________________________

Practice: ______________________________________

Address: ____

Postcode: ____________

Telephone: ________________________ NHS mail: ____

GP Details

GP Name: ______________________________________

GP Address: ____

GP Postcode: ____________ GP Telephone: ________________________

Is surgery requested for the first or second eye? ☐ First Eye ☐ Second Eye

Which eye are you requesting surgery for? ☐ Right Eye ☐ Left Eye

	Sph	Cyl	Axis	VA	Add	Near VA
Right						
Left						

IOP ☐ Right ☐ Left Instrument Used ______________________________

Dilated ☐ Yes ☐ No

Reason if not dilated ____

	No	Right	Left	Both
Previous refractive surgery				
AMD				
Diabetic Retinopathy				
Glaucoma				
Amblyopia				
Corneal opacity				

Current medication: ____

____

Other relevant information (e.g. pseudo exfoliation, Fuch's dystrophy, pupils dilate poorly, unable to lie flat, likely to require G.A)

____

____

Unless all 7 primary boxes are ticked, the patient may not be considered for surgery:

☐ Patient has sufficient cataract to account for the visual symptoms
☐ Patient is interested in being referred for surgery and is willing to undergo surgery if offered
☐ The cataract is affecting the person's vision and quality of life [tick all that apply and **at least one**]:

- ☐ The patient is at significant risk of falls
- ☐ Significantly impaired ability to drive
- ☐ Significantly impaired ability to work
- ☐ Significantly impaired ability to undertake leisure activities (e.g. read, watch TV or recognise faces)
- ☐ Significant glare and dazzle in daylight or having difficulties with night vision
- ☐ There is significant anisometropia causing BV problems/marked refractive non-tolerance

☐ Other significant impact on QOL as a result of visual symptoms (please list)
☐ Patient is a non-smoker or has been advised to contact a smoking cessation service
☐ Referrer has discussed the risks and benefits of cataract surgery with the patient and issued an approved cataract information booklet
☐ Patient understands they are being referred for assessment of surgery initially and that surgery must be approved by the surgeon

STATEMENT: The reason for this referral has been explained to the patient or guardian who agrees to it. The patient or guardian also consents to information being exchanged between the Hospital Eye Service, their General Medical Practitioner, and optometrist or ophthalmic medical practitioner (delete any not consented to).

If appropriate, guardians name and address:

____

____

Signed (optometrist/OMP) ______________________________
GOC/GMC number:______________________________