Anytown LOC/CCG

Cataract Referral Form

Patient's Details
First name:
Last name:
DOB:
NHS number:
Address:
Phone:
Mobile:
Email:

Optometrist / Practice
Optometrist:
OPL number:
Practice:
Phone:

Patient's GP
GP name:
Practice:

	Sph	Cyl	Axis	Prism	VA	Add	Near VA	Pre-cataract VA		IOP(mmHg)	Instrument	Time
R									*Date:*			
L												

Patient dilated?	*Yes*		*No*	
If no, reason:				
Smoker?	*Yes*		*Recent ex*		*No*	
Cataract	*Right*		*Left*	
Preferred eye for surgery	*Right*		*Left*	
Red reflex visible?	*Right*		*Left*	
Prev cataract operation?	*Right*		*Left*	
Prev operation date:				

Any co-existing ocular pathology? *(if yes, please indicate with a tick below)*	*Yes*		*No*	
Significant AMD?	*Right*		*Left*	
Diabetic retinopathy?	*Right*		*Left*	
Amblyopia?	*Right*		*Left*	
Under treatment for glaucoma?	*Yes*		*No*	
Cornea healthy? *(if no, detail below)*	*Yes*		*No*	
Other:				

Patient indicates previous refractive surgery?	*Approx surgery date:*	*Yes*		*No*	
Patient has completed a self-assessment questionnaire? *(required for referral)*		*Yes*		*No*	
Is patient experiencing visual difficulties due to cataracts?		*Yes*		*No*	
Benefits and risks of cataract surgery have been explained?		*Yes*		*No*	
Patient wants cataract surgery at this time? *(if no, inform GP)*		*Yes*		*No*	
Patient has chosen to be referred for NHS treatment? *(choose no for private referrals)*		*Yes*		*No*	
Patient previously assessed and now wishes to be referred?	*Assessment date:*	*Yes*		*No*	
Sight test carried out today? *(if no, indicate date)*	*Sight test date:*	*Yes*		*No*	

Additional comments:	
Signature:	*Date:*

Anytown LOC/CCG

Post-Operative Cataract Report

Patient's Details
First name:
Last name:
DOB:
NHS number:
Address:
Phone:
Mobile:
Email:

Optometrist / Practice
Optometrist:
OPL number:
Practice:
Phone:

Patient's GP
GP name:
Practice:

Procedure details

Procedure undertaken	*Right eye*		*Left eye*	
Pin hole VA	*Right:*		*Left:*	
Comments:				

Consultant:
Treatment centre:
Date of procedure:

Slit lamp examination

Patient gives/has a history of pain, discomfort or sudden reduction in vision?	*Yes*		*No*	
Anterior chamber activity present? (> 2 cells seen in 2x2 mm field)	*Yes*		*No*	
Wound red or unusual in any way?	*Yes*		*No*	
Corneal clarity affected?	*Yes*		*No*	
Posterior synechiae?	*Yes*		*No*	
Thickening or posterior capsule?	*Yes*		*No*	
Any vitreous activity?	*Yes*		*No*	
Intolerable or unacceptable astigmatism?	*Yes*		*No*	
Intolerable or unacceptable anisometropia?	*Yes*		*No*	
Corrected acuity < post-op PH or < 6/12?	*Yes*		*No*	

IOP (mmHg)	*Right eye:*	*Left eye:*

Refraction

	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA
R								
L								

Rx dispensed?	*Yes*		*No*

Action taken / conclusion

Surgical outcome – Px is: *(tick 1 one only)*	*Pleased?*		*Disappointed?*		*Neither?*

***Suitable** for discharge*		***Unsuitable** for discharge send review appointment*		*I have already made arrangements for **urgent referral***	

I confirm that I have carried out the above examination.	*Signature:*	*Date:*