Cataract Post Operative Assessment Form

North Kirklees Clinical Commissioning Group
Greater Huddersfield Clinical Commissioning Group
Calderdale Clinical Commissioning Group
NHS

Patient's Details	Optometrist / Practice
First Name:	Optometrist:
Last Name:	OPL number:
Address: Phone:	Practice Name & Address: Phone:
Patient's signed authorisation for audit release:	

Patient's DOB :		**Practice Patient Ref No:**	

Patient's GP & Address :	
Surgical Provider : **Fax no:**	

Please carry out the following:

☐ Carry out refraction and a post operative assessment. Fax the form back to the provider

Refraction Details

R	Sph	Cyl	Axis	Prism	Add

L	Sph	Cyl	Axis	Prism	Add

Vision Details

Unaided	Pinhole	VA

Unaided	Pinhole	VA

Comments	Yes	No	Clinical Findings	Yes	No	Comments
			Raised IOP (Greater than 21mm)			
			Corneal Oedema / Striae / Decemets Folds			
			Corneal Epithelial Staining			
			Wound / Leak / Rupture			
			Shallow Anterior Chamber			
			Marked Limbal / Conjunctival Injection			
			Post Operative / Iritis / Hypopion			
			Synechiae.			
			IOL Decentered			
			Posterior Capsular Opacification			
			New floaters since surgery			
			Fundus Examined			

☐ Referred back to hospital due to ………………………………………………………………………………….

Signature ……………………………………………..   **Date** ……………………………………