GP COPY – SEE ACTION NOTE BELOW

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

CATARACT REFERRAL FORM

Patient's Details
FIRST NAME:
LAST NAME:
ADDRESS:
PHONE NUMBER:
Practice Px reference No.
Patient's signed authorisation for audit release:
Patient's DOB

Optometrist / Practice
Optometrist:
OPL No.:
Practice:
Phone:

Patient's G.P
GP Name:
Practice:
Patient Ref No.

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

Patient dilated?	YES		NO	
If no, reason				
Cataract	RIGHT		LEFT	
Preferred eye for surgery	RIGHT		LEFT	
Red reflex visible?	RIGHT		LEFT	
Prev. cataract operation? - prev. operation date:	RIGHT		LEFT	

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				

Is the patient experiencing visual difficulties due to cataracts? YES/NO If NO - do not refer using this scheme.

Patient indicates previous refractive surgery? Approx. surgery date:		YES		NO	
Patient has completed a self- assessment questionnaire? (required for referral)		YES		NO	
Does patient drive? If yes ; PRIV/ HGV/ TAXI/ PCV/ OTHER:		YES		NO	
Benefits and risks of cataract surgery have been explained?		YES		NO	
Patient wants cataract surgery at this time? (If no, inform G.P)		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	

Choice of provider :	HRI / CRH / OTHER.
If 2nd eye, who was 1st provider?	

Additional comments:

Gp action required: Please fax patient's abbreviated medical history to provider on:……………………

Optometrist Signature	Date: