|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date: Direct cataract referral for optometrists accredited to Bucks CCG** | | | | | | | | | | |
| Title Surname Other names | | | | | | | | | D.O.B. | |
| Address | | | | | | | | | Tel. no. | |
| Postcode NHS No Hosp No | | | | | | | | |
| GP name GP practice GP code  GP telephone no | | | | | | | | | | |
| **Most recent refraction** | | | Sph | Cyl | Axis | Prism | VA | Ph VA | Add | NVA |
| Date R | | |  |  |  |  |  |  |  |  |
| Dispensed yes / no L | | |  |  |  |  |  |  |  |  |
| **Rx. prior to myopic shift** | | | Sph | Cyl | Axis | Prism | VA | Cataract type | | |
| Date R | | |  |  |  |  |  |  | | |
| L | | |  |  |  |  |  |
|  | | Cornea | C/D ratio | IOP (time & method) | | Macula | | Other observations | | |
| **Dilated Eye Examination** | R |  |  |  | |  | |  | | |
| Date | L |  |  |  | |  | |
| **Information for triage of patients** | | | | | | **Social information** | | | | |
| Insulin controlled diabetic yes / no  Complex medical history (See guidance) yes / no  Unable to transfer from wheelchair yes / no  Unable to lie flat yes / no  Evidence of confusion/dementia yes / no  Presence of head tremor yes / no  Language barrier yes / no  Hearing difficulties yes / no | | | | | | Needs to meet DVLA requirements yes / no  Is still in employment yes / no  Lives alone yes / no  VA 6/12 or better (give symptoms below) yes / no  Pre existing myopia over 6 DS yes / no  Previous corneal refractive surgery yes / no  Fellow eye amblyopic 6/18 or worse yes / no  Fellow eye blind yes / no | | | | |
| **Other relevant information or additional optometrist comments for triage.** | | | | | | | | | | |
| **Medication** | | | | | | | | | | |
| **Previous cataract surgery** yes / no R / L Date Where | | | | | | | | | | |
| Can make own transport arrangements on day of surgery yes / no  Will have support at home on night of surgery yes / no  Booklet has been issued and contents discussed yes / no | | | | | | | | | | |
| **I understand that the main reason for my reduced vision is cataract and I wish to proceed with the cataract operation. I also consent to the provider receiving relevant patient information.** | | | | | | | **Patients signature** | | | |
| **Referring optometrist** | | | | | | Practice address | | | | |
| Name Signature  GOC No. | | | | | |
| One copy to <bht.cataractreferrals@nhs.net>, one copy to GP, another copy to be retained with the patient's record | | | | | | | | | | |