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						

Dilated Eye Examination		Cornea	C/D ratio	IOP (time & method)	Macula	Other observations
	R					
Date	L					

Information for triage of patients		**Social information**	
Insulin controlled diabetic	yes / no	Needs to meet DVLA requirements	yes / no
Complex medical history (See guidance)	yes / no	Is still in employment	yes / no
Unable to transfer from wheelchair	yes / no	Lives alone	yes / no
Unable to lie flat	yes / no	VA 6/12 or better (give symptoms below)	yes / no
Evidence of confusion/dementia	yes / no	Pre existing myopia over 6 DS	yes / no
Presence of head tremor	yes / no	Previous corneal refractive surgery	yes / no
Language barrier	yes / no	Fellow eye amblyopic 6/18 or worse	yes / no
Hearing difficulties	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