Cambridgeshire and Peterborough Clinical Commissioning Group

Direct Referral Form for Cataract Surgery
(Completion by Optometrist or GP and for retention in patient's hospital notes)

It is the responsibility of referring and treating clinicians to ensure compliance with this policy

NOTE for referring Optometrist/GP:

- **For patients who meet the policy threshold criteria complete sections 1, 2 and 3 electronically where possible and send by secure fax to the secondary care service provider - Optician please copy to GP. Click the link to access the CCG Policy.**
- **For patients who do not meet the policy threshold criteria treatment is considered of low priority and will only be commissioned by the NHS on an exceptional case basis. Funding through the Exceptional Case process must be sought prior to referral to secondary care. Complete sections 1, 2, and the smoking statement in section 3, and submit this form to the Exceptional Cases Team by secure email on: cpccge-ifr@nhs.net or secure fax number 01223 725592. The request for funding will be acknowledged and considered by EC Panel at the next available Panel meeting.**
- **In the case of an exceptional funding request, when completing this proforma and where possible, please retain it in its Word format to enable the Exceptional Cases Administrator to complete the Exceptional Cases Panel decision section over page. This proforma will be forwarded to the relevant Eye Department of the location indicated on the form below and copied to the GP/Optician if funding is approved.**
- **Hospital specialist/treating clinician to complete Section 5.**

Section 1: Patient, Optometrist and GP Details		
Patient's Name: **DOB:**	**GP's Name:**	**Optometrist's Name:**
Address: Postcode: Tel No: NHS No:	Address: Postcode: Tel No:	Address: Postcode: Tel No:

Location of proposed intervention	

Note to referring Optometrist or GP: *patient consent statements and referral information must be completed in full before referring to secondary care. Incomplete proforma will be returned.*

Patient Consent	Mark or tick boxes below to confirm
I confirm the patient has consented to sharing of personal and clinical information contained within this proforma with clinical staff involved in their care and for the Exceptional Cases Team or Panel, as part of the exceptional cases process or Group Prior Approval processes, to request further information, clarify data and communicate where applicable with the patient, and for future audit purposes.	
By submitting this request you are confirming that you have reviewed this request against the relevant policy and believe the patient meets the relevant threshold criteria or exceptionality criteria. You have fully explained to the patient the proposed treatment and they have consented to you raising this referral on their behalf.	Enter date of request
I confirm that **it is clinically appropriate** for the patient to be copied into all correspondence.	
I confirm that **it is not clinically appropriate** for the patient to be copied into all correspondence.	
Please confirm that you have brought the CCG patient leaflet on the collection and use of patient data for the funding request process to the patient's attention: 'Why we need to collect your personal confidential information and your rights'. The leaflet is available on the following web page: http://www.cambsphn.nhs.uk/CCPF/ExcptnalandIFR.aspx	

Section 2 : Clinical Detail and Medical History	Mark as appropriate for left or right eye		
Reason for referral:	**Cataract surgery to:**	**Left eye:**	**Right eye:**
Ocular Co-morbidity / POH:			

Rx	**R Sph.**	**Cyl.**	**Axis**	**BC VA**	**L Sph.**	**Cyl**	**Axis**	**BC VA**	**Add**
Current									
Previous									

Cataract Grade

		delete as appropriate			delete as appropriate
R	**Clear**		L	**Clear**	
	Nuclear	mild / mod / severe		**Nuclear**	mild / mod / severe
	Cortical	mild / mod / severe		**Cortical**	mild / mod / severe
	PSC	mild / mod / severe		**PSC**	mild / mod / severe
	Pseudophakia			**Pseudophakia**	

Delete Yes/No below as appropriate

Blepharitis: Yes / No	**A/C depth: Deep / Shallow**	**Pupil dilates well: Yes / No**
Difficult fundoscopy: Yes / No	**RAPD present: Yes / No**	

Cornea:	R:	*L:* Indicate if opacity
IOP:	R: mmHg	*L:* mmHg
Disc:	R:	*L:* Indicate cup-disc ratio
Fundus:	R:	*L:* Indicate macular status

Medical History (to be completed by the Optometrist). Delete Yes/No below as appropriate

Diabetes: Yes / No	Hypertension: Yes / No	Heart attack: Yes / No	Stroke: Yes / No
Short of breath: Yes / No	Poor mobility: Yes / No	Is able to lie down flat: Yes / No	

Current Drugs:

Social History:
(eg driver, working, carer)

Other: delete Yes/No below as appropriate
Transport needed? Yes / No Written information provided? Yes / No

Choice of care provider

Section 3: Cataract Policy Threshold Criteria

For patients with binocular vision or monocular vision where the seeing eye is BCVA ≤6/12 or worse the patient is required to meet the following criteria: Tick boxes as appropriate

	BCVA ≤6/12 or worse in worst eye;	
OR	bilateral cataracts, binocular vision does not meet DVLA standards;	
OR	significant optical imbalance (anisometropia or anisekonia) affecting activities of daily living only corrected with cataract surgery;	
AND	patient is willing to undergo surgery.	
AND	Patient is a non-smoker.	
	OR Patient has been advised of the surgical and post-surgical risks associated with smoking and referred to a smoking cessation service.	
	OR Patient has been advised of the surgical and post-surgical risks associated with smoking, but does not want to be referred to a smoking cessation service.	

Section 4: Case for Exceptionality

Please make the case for exceptionality prior to referral to secondary care for approval of funding.

For patients with monocular vision where the seeing eye has BCVA between 6/6 and 6/12 exceptional funding is required.

Provide full clinical detail below as to why CCG Exceptional Funding is considered appropriate in this case.

Email or Fax the completed referral proforma to the Exceptional Cases Team:
via NHSnet email to cpccge-ifr@nhs.net or secure fax to 01223 725592

For completion by Exceptional Cases Administrator

Tick boxes as appropriate

EC Number:	CP	Date of Exceptional Cases Panel:	

Exceptionality demonstrated.	Funding approved.	
Exceptionality not demonstrated.	Funding declined.	
Inadequate information provided.	Return proforma to GP/Optometrist.	
Other: The policy does not apply.	GP/Optometrist to refer through appropriate pathway.	
Reason:		

Form returned to GP confirming EC Panel decision:		Date:	

Section 5: For completion by Hospital Specialist/Treating Clinician

Tick boxes as appropriate

I agree the patient meets the criteria for surgery or exceptional funding has been approved.						
List for cataract surgery:		Right Eye		Left Eye		
If OCT/USS performed, please give details of clinical indication below:						
I confirm the patient does not meet the policy criteria and exceptional funding has not been approved.						
Proforma returned to referring GP/Optometrist.		Date:				

Name of treating clinician:	**Date:**