Addenbrooke's Hospital

Direct Optometrist Referral Form for Cataract Surgery

NHS
Cambridge University Hospitals
NHS Foundation Trust

Patient's Name: **DOB:** 17/05/2023	**GP's Name:**	**Optometrist's Name:**
Address: Postcode: Tel No: NHS No:	Address: Postcode: Is Patients GP in Cambridgeshire? Yes	Address: Postcode: Tel No: E-mail:

Reason for referral/symptoms:

Ocular Co-morbidity/POH:

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

Cataract Grade *Please select from the drop down boxes*

R			L		
	Clear	☐		**Clear**	☐
	Nuclear	--		**Nuclear**	--
	Cortical	--		**Cortical**	--
	PSC	--		**PSC**	--
	Pseudophakia	☐		**Pseudophakia**	☐

Assessment Details

List for cataract surgery in right or left eye? Select Eye

Pupils dilates well Select
RAPD Select
Blepharitis Select
Difficult fundoscopy Select
Please indicate reasons

Cambridgeshire CCG referral criteria met?	Yes
Less than 6/12 in worst eye?	No
Or Binocular VA less than DVLA standards?	No
*Or (for second eye surgery only) s*ignificant optical imbalance not corrected by modification to glasses/contact lenses?	Not Applicable
AND Willing to undergo surgery?	Yes
AND if patient is a smoker, referral to SSS made?	Not Applicable

Dilated Ocular Examination

IOP Select tonometer type	**R**	**L**
Cornea	**R**	**L**
AC (Van-Herick)	**R**	**L**
Disc	**R**	**L**
Fundus/ Macula	**R**	**L**

Medical History

Please select Yes or No from the drop down boxes

Diabetes: Select
Hypertension: Select
Heart attack: Select
Stroke: Select
Short of breath: Select
Poor mobility: Select
Is able to lie down flat: Select
Dementia: Select

Medication: Warfarin ☐ Insulin ☐ Alpha Blocker ☐ Other

Social History:
(eg driver, working, carer)

Other:
Transport needed? Yes Risks/benefits discussed? Yes Written information provided? Yes Interpreter required? Yes
Is The Patient Hard of hearing? No

Additional information?

Optometrist's signature: _____ Date: _____

Electronic Signatures Accepted

Patient Consent

- Is the patient aware of this referral and the content of this form, and any supporting documents?
- I confirm the patient has consented to the sharing of personal and clinical information contained within this form with clinical staff involved with their care to enable full consideration of this referral
- I confirm the patient has consented to the use of information contained within this referral for audit purposes By submitting this referral you are confirming that you have fully explained to the patient the proposed treatment and they have consented to you raising this referral on their behalf.

Select as appropriate

Yes

Date: _____