**OPEN ACCESS GENERIC REFERRAL FORM**

**PLEASE FAX: 01204 441340 or EMAIL:** **spamedica.referrals@nhs.net** **(secure only from an NHS.net account)**

1. **Referring for: Cataract Surgery** [ ]  **/ YAG Capsulotomy** [ ]  **Referral For: Right**[ ]  **Left**[ ]  **Both**[ ]
2. **After an informed conversation with this patient, they have chosen SpaMedica as their provider of choice** [ ]
3. **Transport Required? Yes**[ ]  **/ No**[ ] (Must be mobile and live over 10 miles from SpaMedica. Appointments within 2 weeks cannot be guaranteed with transport)
4. **Optom post-operative assessment? Yes**[ ]  **/ No**[ ] (On selecting ‘Yes’ you are indicating yourself or another within the practice is accredited by SpaMedica and will perform the cataract post-op assessment (name)
5. **Patient consent for SpaMedica to obtain medical summary:** I give consent for my GP to release my medical summary to SpaMedica (Patient signature)

**Section 1 – to be completed by Optometrist**

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| **Name:**  | **GP’s Name:**  | **Optometrist’s Name:**  |
| **Date of Birth:**  |
| **Address:** | **Address:**  | **Address:**  |
| **Post Code:**  | **Post Code:**  | **Post Code:**  |
| **Tel No:**  | **Tel No:**  | **Fax No:**  |
| **Tel No:**  |

**I have explained the benefits and risks of surgery: Yes**[ ]  **/ No**[ ]  **/ N/A**[ ]

**The patient wants surgery: Yes**[ ]  **/ No**[ ]  **/ N/A**[ ]

**The patient has significantly impaired visual function: Yes**[ ]  **/ No**[ ]  **/ N/A**[ ]

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|  |  | **SPh** | **Cyl** | **Axis** | **Prism** | **Add** | **VA** | **Near** | **IOP AT/NCT** |
| **Previous refraction** | **R** |  |  |  |  |  |  |  | **Mm/Hg** |
| **Date** | **L** |  |  |  |  |  |  |  | **Mm/Hg** |
| **Current refraction** | **R** |  |  |  |  |  |  |  | **Mm/Hg** |
| **Date** | **L** |  |  |  |  |  |  |  | **Mm/Hg** |

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| **Lens R** Clear[ ]  Nuc[ ] Cor[ ] PSC[ ]   | **Lens L**Clear[ ] Nuc[ ] Cor[ ] PSC[ ]  |

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| **Cornea R** [ ]  **Healthy** [ ]  **L** **Macula R** [ ]  **Healthy** [ ]  **L Comments** **Discs R** [ ]  **Healthy** [ ]  **L Pupils dilated Yes** [ ]  **No** [ ] **Squint**[ ]  **/ Amblyopia**[ ]  **/ Other**[ ]  **Comments** |

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| **Patient requires interpreter Yes**[ ]  **/ No**[ ]  **Language:** **Please tick for any quality of life or independence lifestyle issues caused by cataract: Driving** [ ] **Work** [ ]  **Binocular Vision** [ ]  **Cooking** [ ]  **Shopping** [ ]  **Mobility** [ ]  **Independence** [ ] **Special Visual Needs** [ ]  **Reading** [ ] **Giving Care** [ ]  **Other Disabilities** [ ] **Other/Comments** **Signature: Print Name: Date:**  |

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| **Section 2 – To be completed if felt appropriate by General Medical Practitioner**Further Clinical Details:Signature: Date:  |