**OPEN ACCESS GENERIC REFERRAL FORM**

**PLEASE FAX: 01204 441340 or EMAIL:** [**spamedica.referrals@nhs.net**](mailto: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** |

|  |  |
| --- | --- |
| **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: |