

**Derbyshire PLCV Referral Form – Optometrists**  
**for**  
**Cataract Surgery (1<sup>st</sup> and/or 2<sup>nd</sup> eye)**

<b>Name of Referring Optometrist:</b>	
<b>Name and Address of Optom's Practice</b>	
<b>Contact Telephone No:</b>	

Patient details	
<b>Surname</b>	
<b>Forename(s)</b>	
<b>Date of birth</b>	
<b>NHS Number</b>	
<b>GP Practice</b>	

**Patient Consent**

	Mark or tick boxes below to confirm
By submitting this request you are confirming that you have reviewed this request against relevant policy and believe the patient meets the relevant threshold criteria and therefore you have fully explained to the patient the proposed treatment and they have consented to you raising this referral on their behalf.	<input type="checkbox"/>

**Part A - PLCV Criteria** **At least ONE must apply**

<b>First Eye</b> Cataract surgery will be funded where the visual acuity after refractive correction is 6/9 or worse in the worst eye (the eye to be treated)	<input type="checkbox"/>
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**OR the patient has one of the following (with correction):** **At least ONE must apply**

Reduced mobility, experiencing difficulties in driving, for example, due to glare, or experiencing difficulty with steps or uneven ground. Ability to work, give care or live independently is affected	<input type="checkbox"/>
The patient has diabetes, or retinal condition, and requires clear views of their retina to monitor their disease or treatment	<input type="checkbox"/>
The patient has glaucoma and requires cataract surgery to control the intra ocular pressure	<input type="checkbox"/>
The patient has posterior subcapsular or cortical cataracts and experiences problems with glare and a reduction in acuity in bright conditions	<input type="checkbox"/>
The patient's visual field defects are borderline for driving, and cataract extraction would be expected to significantly improve the visual field	<input type="checkbox"/>

Cataract surgery in the second eye will ONLY be funded if:	At Least ONE must apply
The first does not achieve an acuity of 6/9 or better, with refractive correction, and the procedure is clinically indicated for the patient's individual circumstances.	<input type="checkbox"/>
The patient has diabetes, or retinal condition, and requires clear views of their retina to monitor their disease or treatment.	<input type="checkbox"/>
The patient has glaucoma and requires cataract surgery to control the intra ocular pressure.	<input type="checkbox"/>
There is, after first eye operation, resultant anisometropia (a large refractive difference between the two eyes) which would result in diplopia (double vision)	<input type="checkbox"/>
An uncorrectable loss of acuity in the second eye (with first eye corrected) that effectively renders the second eye vision worse than 6/24.	<input type="checkbox"/>
This information, together with a report from a recent sight test, should form the minimum data on the referral form.	

Additional Patient Information	BOTH must apply
This patient is willing to undergo a surgical procedure should it be offered.	<input type="checkbox"/>
I have discussed with the patient the fact they will be referred for a possible procedure but there is no guarantee that a surgical intervention will be the required outcome following the consultation with the secondary care specialist.	<input type="checkbox"/>

<b>Prior Approval No :</b> (added by Secondary Care Provider)	
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Secondary Care Provider	
Name of Hospital where referral will be sent	

I confirm that the patient meets the current clinical guideline/policy for referral for the procedure.	
Name of referrer: _____	Date: _____

<b>Please note any individual patient requirements here (e.g. Wheelchair user).</b>

**THIS FORM MUST BE COMPLETED AND SUBMITTED WITH THE:**

- **GOS REFERRAL FORM**

