Cataract Referral (Meets VA Criteria)

fax to: **01626 883772 /** or email to: **d-ccg.drss-ophthalmology@nhs.net**

Date of referral:	Patient's Address:
Title:	
Forenames:	
Surname:	
Date of Birth:	Postcode:
Email Address:	NHS Number (i*f known*):
Home Tel:	Work/Mobile Tel:
Referring Ophthalmic Practitioner's Details	**Patient's Current GP Details**
Practitioner's Name:	GP's Name:
Practice Address:	GP Practice Address:
Practice Tel:	

Patient's Details:

Eye	Vision/ VA	Sph	Cyl	Axis	Prism	VA	PH	Add	Near VA	Previous VA + Date:
Right										
Left										

IOP	Time of IOP:	**Visual Fields: (Delete as applicable)**	**Disc Appearance:**
Right	mmHg	Normal / Defective / Unreliable / Not Possible	
Left	mmHg	Normal / Defective / Unreliable / Not Possible	

Type of Tonometer:		Visual Fields Instrument:	

Findings and Explanation:

1. **Patient understands that purpose of referral is for the assessment for surgery** ❑
2. **Patient wishes surgery** ❑
3. **Patient meets the criteria for cataract surgery** ❑

<u>Patient Meets VA Criteria:</u>

Best corrected VA of 6/12 or worse in the affected eye AND the patient experiences one or more of the following due to subjective loss of visual performance:

- **Difficulty in accomplishing everyday tasks** ❑
- **Reduced mobility, visual problems when driving or experiencing difficulty with steps or uneven ground** ❑
- **Ability to work, act as a carer or live independently is affected** ❑
- **Patient experiences disabling problems with glare and a reduction in acuity in daylight or bright light conditions or reduced contrast sensitivity** ❑

❑Cycloplegic Refraction	❑ Dilated Fundus Examination	❑ DSS to initiate contact with patient

Does the patient have a disability? If yes please specify:

STATEMENT: The reason for this referral has been explained to the patient or guardian who agrees to it. The patient or guardian also consents to information being exchanged between the Hospital Eye Service, their General Medical Practitioner and Optometrist or Ophthalmic Medical Practitioner (Please tick if patient does not consent: ❑).

Practitioner Signature:_____ Date:_____