FORM E: **Community Post Cataract Operation Report Form**

Please forward completed form to the Ophthalmology Secretary at the hospital that carried out the Cataract Surgery

(NB Post Op Form & 2nd eye Cataract Assessment Questionnaire (CAQ) does not need to be sent to the GP)

Patient Details (please print or type)

Surname:	**First Name:**	
Address:	**DoB:**	**Male / Female (delete as appropriate)**
	Telephone Number (to be provided by hospital):	
Postcode:	**NHS Number:**	

The above named patient underwent RIGHT /LEFT cataract surgery on / /

Their Consultant is: _____ Date of visit: / /

The above named patient has been listed for 2nd eye surgery Yes ☐ No ☐

(The following is to be completed by the Optometrist)

	RIGHT	LEFT
Unaided visions	6/	6/
REFRACTION		
(minus cyl form) SPH		
CYL and AXIS		
BEST-CORRECTED VA	6/	6/
NEAR ADD		
NEAR VA		
SLIT-LAMP EXAM lids		
conjunctiva		
cornea		
anterior chamber		
pupil		
IOL		
Tonometry reading		
Instrument used		

Patient would like to be listed for second eye cataract surgery Yes ☐ No ☐
If yes, please also enclose CAQ for 2nd eye.

Current Anisometropia ≥2.50D Yes ☐ No ☐
If yes, the patient will automatically meet criteria for 2nd eye surgery. CAQ not required.

Additional Comments including any exceptional circumstances for 2nd eye cataract surgery: **(enclose CAQ and use additional sheet if necessary)**

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PATIENT REPORT

Please ask the patient these questions and record their answers.

Is your vision better?

Are you experiencing any discomfort?

Did you complete you course of post-op drops?

Any other comments?

OPTOMETRIST/OMP DETAILS

Name:

Optometrist/OMP – GOC/GMC No:

Address/Practice Stamp

Accredited:
East Sussex Healthcare Trust ☐
Brighton & Sussex Uni Hosp Trust ☐
WOPEC ☐

When this form has been completed take a copy for your own records, then please send all three pages by post to the Ophthalmology Department Secretaries at the appropriate hospital for verification –

***Delete as appropriate**

*EDGH	*Conquest Hospital	*Sussex Eye Hospital	*Spire Tunbridge Wells Hospital
Kings Drive	The Ridge	Eastern Road	Fordcombe Road
Eastbourne	St Leonards on Sea	Brighton	Fordcombe
BN21 2UD	TN37 7RD	BN2 5BF	Tunbridge Wells TN3 0RD

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(Page 1 & 2 should be retained by the provider for insertion of the patient's notes)

VERIFICATION SLIP

Part 1 of this page to be completed by the **Optometrist and forward to the provider for verification**

I confirm I have completed a post-cataract surgery appointment on the following patient and are therefore due the appropriate fee.

Patient name:	
DoB:	**Postcode:**

OPTOMETRIST/OMP DETAILS

Name:

Optometrist/OMP – GOC/GMC No:

Address/Practice Stamp

Accredited:

East Sussex Healthcare Trust ☐
Brighton & Sussex Uni Hosp Trust ☐
WOPEC ☐

Date:

Part 2 – HOSPITAL USE ONLY – For Operating Clinician (or Representative) use only:

Verified by:

Position:

Signature of Operating Clinician:-

Date:-

Patient has been listed for second eye cataract surgery Yes ☐ No ☐

(Payment cannot be processed without verification)

Once completed, this page should be returned to the Optometrist for their records.