YAG Laser Capsulotomy Referral Form - East Sussex

|  |
| --- |
| **\*\* Please print clearly in capitals\*\***  |
| **PATIENT DETAILS (Please Print)** |
| Surname:       |  | First Name:       | Title:       |
| Address:       |  | D.O.B.        | Sex: M F |
|        |  | NHS No:        |
|        |  | Day time Tel. No:       |
| Postcode:       |  | Best time to call patient:       |
| GP DETAILS |  |  |  |
| GP Name:       |  |  |
| Address:       |  |  |
|        |  |  |

**TO BE COMPLETED BY THE OPTOMETRIST/OMP** The above named patient underwent RIGHT cataract surgery on and/or LEFT cataract surgery on

**Visual acuity after surgery if known ; Date**

**Refraction details from current sight test**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | V | Sph | Cyl | Axis | Prism | Base | VA | Add | Near VA |
|  RE |       |       |       |       |       |       |       |       |       |
|  LE |       |       |       |       |       |       |       |       |       |

**Intra-Ocular Pressures**: RE…………………………………LE………………………………………

□ I confirm I have checked this patient’s fundi through dilated pupils. (optional)

I am referring this patient for YAG capsulotomy in their Right /Left/ both eye(s). Please circle.

|  |
| --- |
|  Other ocular pathology and relevant information: eg Amblyopia, previous retinal detachment, AMD (existing/new)      |
|  |
|  OPTOMETRIST / OMP DETAILS |  |  |   |
|  Name:       |  |  Optometrist/ OMP- GOC/ GMC No:       |
|  Address:       |  |   |
| I declare that the information I have given on this form is correct and complete. I consent to the disclosure of the relevant information.  |
|  Signature:       |  | Date:       |
|  Print:       |  |  |

**Please Fax to Eastbourne District General Hospital (01323 414929) or Conquest (01424 758146 or email Conquest on esh-tr.OphthalmologyCasualtyConquest@nhs.net )**