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 email [esht.ophthalmologyappointments@nhs.net](mailto:esht.ophthalmologyappointments@nhs.net)