YAG Laser Capsulotomy Referral Form - East Sussex

PATIENT DETAILS (Please Print)

Title:	First name:	Surname:	D.O.B.
Address:		NHS No.	Sex: M ☐ F ☐
		Day time Tel. No:	
		Alternate contact No:	
Postcode:		Best time to call patient:	
GP Name:		GP address:	
GP Contact number:			

TO BE COMPLETED BY THE OPTOMETRIST/OMP

The named patient underwent cataract surgery on:

RIGHT EYE ☐	Date:	LEFT EYE ☐	Date:

Refraction details from current sight test

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

Intra-Ocular Pressures:	RIGHT EYE	LEFT EYE

I confirm I have checked this patient's fundi through dilated pupils. (optional): ☐

I am referring this patient via e-RS. ☐	**GP, please refer this patient.** ☐

This is a referral for YAG capsulotomy for the Right /Left/ both eye(s). Please select.

RIGHT EYE ☐	LEFT EYE ☐	BOTH EYES ☐

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:	Print:	Date