Cataract Outcome Form

Hull & East Yorkshire Eye Hospital

Place patient Identification sticker here

Pt's Name

HEY № **DoB**

Message to Patient: Once you have finished your drops, please phone your Optometrist to book a sight test, and take this form with you when you go. Thank you.

Consultant: AB AE CB CV ER HA KM MC OS RS SJ UM

Lead Surgeon - if not consultant:

RE		**HOSPITAL USE ONLY**	*LE*	
1st	2nd	1st or 2nd Eye	1st	2nd
		Operation Date		
		Predicted Spherical Equivalent		
HAIGIS L H-Q BARRETT SRK-T (if previous LASIK/LASEK)		Formula Used	HAIGIS L H-Q BARRETT SRK-T (if previous LASIK/LASEK)	
		Pre-op BCVA		
		Co-morbidities (inc. previous surgery)		

Fold

RE Lens Implant Sticker	*LE* Lens Implant Sticker

Optometrist: Please complete all sections below

	R Unaided Vision	Sph	Cyl	Axis	Prism	BCVA	L Unaided Vision	Sph	Cyl	Axis	Prism	BCVA
Distance												
Near												

RE	Examination	*LE*
Yes / NO	Clear Cornea	Yes / NO
Yes / NO	Quiet Anterior Chamber	Yes / NO
Yes / NO	Peaked Pupil	Yes / NO
Yes / NO	Displaced IOL	Yes / NO
Yes / NO	Iris Trauma	Yes / NO
Yes / NO	Iris Prolapse	Yes / NO
IOP: NCT/GAT Time:	IOP	IOP: NCT/GAT Time:
Yes / NO / UNKNOWN	CMO	Yes / NO / UNKNOWN
Yes / NO	Wet AMD	Yes / NO
Yes / NO	Dry AMD	Yes / NO

Fold

Please return to:
Ophthalmology Audit Officer
Hull and East Yorkshire Eye Hospital, Fountain Street
Hull, HU3 2JZ
Audit queries: 01482 604347
Payment queries: 01482 604360
01482 674656

Optometrist Local Cataract Code

Practice Address/Stamp for payment purposes

Please complete all sections of the form and return it to the address above. By agreement with the CCGs, you may claim a sight test fee under code 5.1. An additional fee of £45 will be paid on receipt of the form, on condition it is returned within 12 weeks of surgery, and the sight test follows completion of the course of drops. This is payable on completion of single eye only referrals or on completion of second eye surgery on bilateral referral pathways. This is payable from surgeries completed after Monday 16th September only. Any surgeries prior, will be paid at the previously agreed £12.50.

Other/ Comments by Optometrist:

Optometrist Signature: **Dated:**

OPTOMETRIST USE (TABLE + STATEMENT BELOW)

Please ask patient to sign:-

I hereby give consent for the details below to be disclosed over the phone to the Pre-op Office at the Hull & East Yorkshire Eye Hospital, for the purpose of further cataract surgery.

Patient Signature: **Date:**