|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | **Cataract Pre-Referral Form**  **If you are referring a patient to SpaMedica by ANY means including via Fax, Royal Mail, GP, Webstar or Referral Management Centre:**  **Please complete below and fax to 0161 835 1704 or Email to** [**Referrals@spamedica.co.uk**](mailto:Referrals@spamedica.co.uk)  **This form is only requested from you, if you are not using a SpaMedica ‘Open Access Generic Referral Form’** | | | | | | | | | | | | | | |
| **REFERRAL DETAILS (PLEASE CIRCLE)** | | | | | | | | | | | | | |
| SpaMedica Location? | | | | Manchester | | Newton-Le-Willows | | | Birkenhead | | Liverpool | Wakefield | |
| SpaMedica Transport? | | | | Yes | | | | | No | | | | |
| Optom Post-op Assessment? | | | | Yes **\*** | | | | | No | | | | |
| **\***On circling ‘Yes’ you are indicating yourself or (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ within the practice is accredited by SpaMedica and will perform the cataract post-op assessment | | | | | | | | | | | | | |
| Does your patient have a pacemaker? | | | | | Yes | | | | No | | | | |
| Does your patient have a latex allergy? | | | | | Yes | | | | No | | | | |
|  | | | | | | | | | | | | | |
| patient details: | | | | | | | | | | | | | |
| 1 | | Full Name | First name | | | | | Surname | | | | | |
| 2 | | Contact Number |  | | | | | | | | | | |
| 3 | | DOB | Day | | | | Month | | | Year | | | |
| 4 | | Post-Code |  | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Practice details: | | | | | | | | | | | | | |
| 1. | Referrer Name | |  | | | | | | | | | | |
| 2. | Practice Name | |  | | | | | | | | | | |
| 3. | Practice Post-Code | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Method Of referral: (Please Tick) | | | | | | | | | | | | | |
| 1. | Via GP | | | | | | | | | | | |  |
| 2. | Referral Management Centre / Patient Choice Team | | | | | | | | | | | |  |
| 3. | Webstar / Optomanager | | | | | | | | | | | |  |
| 4 | Direct Referral to SpaMedica (via either fax/email/post) | | | | | | | | | | | |  |
| 4. | Other (Please state) | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | |
| DATE REFERRAL MADE: | | | | | | | | | | | | | |
| Date | | | Day | | | | Month | | | Year | | | |



**Why am I being asked to supply this information?** We wish to prevent any incidents whereby referrals made to SpaMedica are lost or held-up in the ‘system’. We ask for an extra few seconds of your time so that we can ensure that patients can receive prompt treatment. We will not arrange appointments until we receive the referral itself.