 **OPEN ACCESS GENERIC REFERRAL FORM**

**PLEASE FAX: 0161 835 1704 / 0161 839 1423 or EMAIL:** [**referrals@spamedica.co.uk**](mailto:referrals@spamedica.co.uk) **or** [**spamedica.referrals@nhs.net**](mailto:spamedica.referrals@nhs.net)

**1: Referring for: Cataract Surgery / YAG** [**Capsulotomy**](https://www.google.co.uk/search?biw=1600&bih=805&q=YAG+Capsulotomy&spell=1&sa=X&ei=DxlbVfv_LcPj7QbvwYDIAQ&ved=0CBoQvwUoAA) **/ Other**

**2: Patient choice of SpaMedica hospital: Manchester / Newton Le Willows / Wirral / Liverpool / Wakefield**

**3: Transport Required? Yes / No** (Must be mobile and live within 10-30 miles of SpaMedica. Appointments within 2 weeks cannot be guaranteed with transport)

**4: Optom post-operative assessment? Yes / No** (On selecting ‘Yes’ you are indicating yourself or (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ within the practice is accredited by SpaMedica and will perform the cataract post-op assessment)

**5: Does your patient have a pacemaker? Yes / No**

**6: Does your patient have a latex allergy? Yes / No**

**Section 1 – to be completed by Optometrist**

Patients Name: GP’s Name: Optometrist’s Name

Date Of Birth: Address: Address:

Address:

Post Code:

Post Code: Post Code: Fax No:

Tel No: Tel No: Tel No:

I have explained the benefits and risks of surgery: Yes / No / N/A

The patient wants surgery: Yes / No / N/A

The patient has significantly impaired visual function: Yes / No

SPh Cyl Axis Prism Add VA Near IOP AT/NCT

Previous refraction  **R** mm/Hg

Date **L** mm/Hg

Current refraction **R** mm/Hg

Date **L** mm/Hg

Lens **R** ClearLens **L** Clear

Nuc Nuc

Cor Cor

PSC PSC

Cornea R Healthy L Comments................................................................................................

Macula R Healthy L Pupils dilated

Discs R Healthy L Size...................mm

Squint / Amblyopia / Other Comment...................................................................................................................

Patient requires interpreter Yes / No Language................................................................................................ ......

Comments..................................................................................................................................................................... .....

Social Driver Yes / No Special Visual Needs Yes / No

Comments..................................................................................................................................................................... .....

Signature............................................ Print Name........................................................................ Date............................

**Section 2 – To be completed if felt appropriate by General Medical Practitioner**

Further Clinical Details:

Signature............................................................................. Date..............................