**RCCG Cataract Assessment / Referral Form**

**First Eye Surgery: Please complete Part 1 and 2.**

**Second Eye Surgery: Please complete Part 1 and 3.**

**Part 1 - Assessment**

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| --- | --- | --- | --- | --- | --- |
| **GP Name:** | …………………………………………… | | **Patient Surname:** | | ………………….… Title:….…….. |
| Address: | …………………………………………… | | Forename(s): | | ……………………………………….. |
|  | …………………………………………… | | Date of Birth: | | ……………………………………….. |
| Postcode: | ……………. Tel: ……………………… | | Address: | | ……………………………………….. |
| **Optometrist Name:** | | ………………………………… |  | | ……………………………………….. |
| Address: | …………………………………………… | | Postcode: | | ……………………………………….. |
| Postcode: | ………………Tel: ……………………… | | Tel 1: | ……………………… Tel 2:….…………………. | |

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| **VA Scores\***  VA 6/6 = 0 |  | **SPH** | **CYL** | **AXS** | **VA** | **Dominant Eye** | **Score** |  |
| VA 6/9 = 1  VA 6-12 = 2 | **R** |  |  |  |  |  |  | **VA Score** |
| VA 6/18 and above = 7 | **L** |  |  |  |  |  |  |  |

|  |  |  |  |  |
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| **Lifestyle Questions to ask a Patient\*** | **Not at all** | **Slightly** | **Moderately** | **Very Much** |
| Is the patient’s quality of life affected by vision difficulties (*e.g. car driving, watching TV, doing hobbies etc*)? |  |  |  |  |
| Is the patient’s social functioning affected by vision difficulties (*e.g. crossing roads, recognising people, recognising coins etc*)? |  |  |  |  |

\* These questions are designed to elicit the information from patients as to the effect on their lifestyle. The clinician will use the responses to weight the scoring below.

|  |  |  |
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| Please circle | **Yes** | **No** |
| Any difficulties for patient with mobility *(including aspect of travel e.g. driving, using buses)*? | 2 | 0 |
| Is the patient affected by glare in sunlight or night *(car headlights)*? | 2 | 0 |
| Is patient’s vision affecting their ability to carry out daily tasks? | 2 | 0 |

**Part 2 – First Eye Cataract Surgery**

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| **FIRST EYE TOTAL ASSESSMENT SCORE** (VA AND LIFESTYLE SCORE) | | | | |  |
| **NB: THE PATIENT MUST HAVE A TOTAL ASSESSMENT SCORE OF 7 TO MEET THE THRESHOLD FOR FIRST EYE** **SURGERY OR THE PATIENT MEETS ONE THE EXCEPTIONS (PLEASE DOCUMENT IN PART 4)** | | | | | |
|  | Patient meets the Clinical Threshold and requires Referral | |  | Patient Doesn’t Require Referral | |
| **Referred to (name of provider):** | | ……………………………………………………………………………………. | | | |

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| **Important: A patient with a total assessment of under 7 should be advised that a referral for a cataract operation is not essential at this time, unless they meet one of the exception criteria listed below. The patient should be advised to return for a further assessment as and when you see fit.** |

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| **Part 3 – Second Eye Cataract Surgery**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **SECOND EYE TOTAL ASSESSMENT SCORE** (VA AND LIFESTYLE SCORE) | | | | |  | | **NB: THE PATIENT MUST HAVE A TOTAL ASSESSMENT SCORE OF 7 TO MEET THE THRESHOLD FOR FIRST EYE** **SURGERY OR THE PATIENT MEETS ONE THE EXCEPTIONS (PLEASE DOCUMENT IN PART 4)** | | | | | | |  | Patient meets the Clinical Threshold and requires Referral | |  | Patient Doesn’t Require Referral | | | **Referred to (name of provider):** | | ……………………………………………………………………………………. | | | |  |  | | --- | | **Important: A patient with a total assessment of under 7 should be advised that a referral for a cataract operation is not essential at this time, unless they meet one of the exception criteria listed below. The patient should be advised to return for a further assessment as and when you see fit.** |   Previous stable refraction prior to cataract development (if available and if referring): | | | | | | | | | | |
|  | **SPH** | **CYL** | **AXS** | **VA** |  | **SPH** | **CYL** | **AXS** | **VA** | **DATE** |
| **R** |  |  |  |  | **L** |  |  |  |  |  |

**Part 4 - Exceptions**

Exceptions are applicable to first or second eye

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| **The only exceptions to the referral criteria are as follows:** | **Delete as appropriate** | |
| Anisometropia (a large refractive difference between the two eyes, on average about 3 dioptres), which would result in poor binocular vision or disabling diplopia which may increase the risk of falls. | Yes | No |
| Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma | Yes | No |
| Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management. | Yes | No |
| Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery | Yes | No |
| Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty) | Yes | No |
| Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis) | Yes | No |
| Other glaucoma’s (including open-angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography | Yes | No |
| Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes) | Yes | No |
| Post vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia. | Yes | No |

**If a clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG’s Individual Funding Request policy for further information:** <http://www.rotherhamccg.nhs.uk/South%20Yorkshire%20and%20Bassetlaw%20Commissioning%20for%20Outcomes%20Policy%20v21%20FINAL%2001.05.19.pdf>

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| **Interpreter required?** | No | Yes | | Language: …………………………………….. | |
| I understand that I am being referred for surgical assessment and I have received an information leaflet explaining this. Furthermore, I am willing to consider surgery if this is felt necessary. | | | | | |
| **Patients Signature:** | …………………………… | | **Date:** | ………………………………………………….. | |
| **Signed:** (Optometrist/OMP) | …………………………… | | **Referral date:** ……….. | | **GOC/GMC No**: …………… |
|  |  |  | |  | |