West Yorkshire Association of Acute Trusts

West Yorkshire Health and Care Partnership

WY Single Point of Access Cataract Referral

Patient Name: Click or tap here to enter text.	**Date of Birth:** Click or tap to enter a date.	**Gender:** Choose an item.
Patient Address: Click or tap here to enter text.	**Post code:** Click or tap here to enter text.	
Telephone: Click or tap here to enter text.	**Occupation:** Click or tap here to enter text.	
Driver: Choose an item.	**NHS Number:** Click or tap here to enter text.	

Optometrist: Click or tap here to enter text.	**GOC Number:** Click or tap here to enter text.	**General Practitioner Name** Click or tap here to enter text.
Practice & address: Click or tap here to enter text.	**Postcode:** Click or tap here to enter text.	**Address** Click or tap here to enter text.
Practice NHS.net address: Click or tap here to enter text.	**Telephone:** Click or tap here to enter text.	**Postcode:** Click or tap here to enter text. **Telephone:** Click or tap here to enter text.

Visual Status		Right	VA	Left	VA
Current Refraction (Date: Click or tap to enter a date.)	**Dist**	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
	Near	Click or tap here to enter text.		Click or tap here to enter text.	
Pre-cataract Refraction (Date: Click or tap to enter a date.)	**Dist**	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
	Near	Click or tap here to enter text.		Click or tap here to enter text.	
Type of Cataract		Choose an item.		Choose an item.	
Any other eye co-morbidities (inc ARMD, corneal, glaucoma etc)		Click or tap here to enter text.		Click or tap here to enter text.	
IOP: Method: Choose an item.		Click or tap here to enter text.		Click or tap here to enter text.	
Corneal guttae (Fuchs endothelial dystrophy)		Choose an item.		Choose an item.	
Corneal scarring		Choose an item.		Choose an item.	
Pseudoexfoliation		Choose an item.		Choose an item.	
RAPD		Choose an item.		Choose an item.	

Dilated: Choose an item.	**Condition of posterior pole:** Click or tap here to enter text.	**Eye for surgery:** Choose an item.	**1st / 2nd Eye:** Choose an item.
Prior refractive surgery: Choose an item.	**Refractive surgery detail:** Choose an item.	**Contact Lens:** Choose an item.	**Priority:** Choose an item.

Discussion / Shared Decision Making
Quality of Life Questionnaire must be completed and retained by practice

☐ Patient informed of cataract diagnosis

☐ Cataract surgery recommended to patient (bearing other visual co-morbidities in mind)

☐ Risks versus benefits of surgery discussed – *read to patient:*

Most people do very well with cataract surgery but there are a small number of complications which include a 1 in 1000 chance of complete loss of sight in the operated eye. Some people have other conditions like diabetes which may affect their final result.

☐ Patient informed of likely consequences if surgical treatment declined

☐ Patient has agreed to be referred to proceed with surgery

☐ Cataract is significantly affecting the patient's vision, daily activities and quality of life

☐ Patient been given information leaflet

☐ Agreed first eye for surgery: Choose an item.

Top Copy to SPoA, **2nd Copy** to GP FOR INFORMATION ONLY, **3rd Copy** retained by optometrist, **4th Copy** to patient.

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Language: Click or tap here to enter text. Hospital translator service needed: Choose an item.	**Transport** Hospital transport needed: Choose an item.

Choice of provider will be given to the patient through the EyeV system. The patient will be contacted post submission of this referral. The system will contact the patient via text on their mobile first.

Best time to contact patient: Choose an item.   Mobile number (text/call): Click or tap here to enter text.
Landline number: Click or tap here to enter text. Email address:Click or tap here to enter text.

☐ **This patient is <u>NOT</u> suitable for automated choice decision through EyeV –** for example, patient has severe dementia, learning difficulties or cognitive difficulties. **Please detail reason:** Click or tap here to enter text.

Other Comments or Relevant Medical History:	Click or tap here to enter text.	**Date:** Click or tap to enter a date.
Optometrist Signature:	Click or tap here to enter text.	

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