CATARACT REFERRAL FORM

Title (Dr / Mr / Miss / Mrs / Ms)			
Surname			
Other names			
Address			
Post Code			
Daytime Telephone Number			
Date of Birth		**NHS Number**	
GP Practice			

First Cataract ☐						**Second Cataract** ☐					
Prescription details from current sight test										**Date**	
	Unco - rrected Vision	**Sph**	**Cyl**	**Axis**	**Prism**	**Base**	**VA**	**Add**	**Near VA**	**Previous corrected VA**	
										Date	
RE											
LE											

		RE			**LE**	
Disc Appearance						
Intra-Occular Pressure (mmHg)						
Tonometer used	**Pneumo** ☐		**Applanation** ☐		**icare** ☐	

First Eye BCVA 6/12 or worse ☐	**Second Eye BCVA 6/18 or worse** ☐	**Symptoms resulting in detriment to quality of life, in particular compromising independence** ☐			
Referrals for Cataract surgery will be approved without consideration of the level of BCVA where it is in the patient's best interests and where ANY of the following criteria apply. Please tick which of the indications below are applicable to your patient (Please see notes for more detail regarding the criteria to be met)					
Glare ☐	**Diabetic Retinopathy** ☐	**Glaucoma / intraocular pressure control** ☐		**Anisometropia** ☐	
Risk of Falls / Carer ☐	**Rapid cataract-induced myopic shift** ☐	**DVLA visual requirements** ☐		**Unable to measure Visual Acuity** ☐	
Description of cataract and any known co-morbidities / Extenuating circumstances					
I confirm that this patient meets the criteria as detailed in the WNCCG Cataract Surgery Criteria and indicated above ☐					
Name and Address of Optometrist/OMP					

SEND TO: **nwicb.cataract@nhs.net** (Nowich, North and South Norfolk)