CATARACT REFERRAL FORM -

NHS

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**	
	Un-corrected 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** ☐	

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.
Information on full cataract surgery policy referral criteria can be found on the Knowledge NoW website
If the patient does not fulfil the policy referral criteria but has exceptional circumstances that may warrant the procedure, an Individual Funding Application form can be completed and sent to; nw.ifr@nhs.net

Visual disability impacting on daily activities or employment	☐	**Driver – DVLA visual requirements**	☐	**Glare**	☐	**Risk of Falls**	☐
Carer	☐	**Anisometropia**	☐	**Myopic shift or refractive error**	☐	**Glaucoma**	☐
Narrow Angles	☐	**Diabetes**	☐	☐ **Other**	☐		

Description of cataract and any known co-morbidities / Extenuating circumstances

I confirm that this patient meets the criteria as detailed in the NWICB Cataract Surgery Criteria and indicated above ☐

Name and Address of Optometrist/OMP

SEND TO: **nwicb.cataract@nhs.net** (Norwich, North Norfolk and South Norfolk) September 2024