OPTOMETRIC CATARACT ONLY REFERRAL FORM

OPTOMETRIST	**GENERAL MEDICAL PRACTITIONER**
Name: Ophthalmic List no / Personal code: Practice address: Signature: Date:	Name: Cypher no: Practice stamp: Signature: Date:

PATIENT DETAILS

Title:	**Surname:**	**First Name(s):**
Health & Care No:		**Date of birth:**
Address:		
Postcode:		**Tel No:**
Date of Eye Examination:		

REFRACTION DETAILS

	Unaided vision	**Sph**	**Cyl**	**Axis**	**VA**	**Add**	**Near VA**	**Previous VA**	**Date of previous VA**
R									
L									
IOP	**R**	**L**		**Time:**		**Instrument:**			

Indication for referral / co-morbidities:

Has patient had refractive surgery Yes / No *(delete as appropriate)*

General Health/Medication/Ocular History:

Is patient a driver Yes / No *(delete as appropriate)*

CHECKLIST

Is the presence of cataract impacting on the patient's quality of life?	Yes / No *(delete)*
Has the patient been informed of the nature of cataract surgery?	Yes / No *(delete)*
Have you confirmed with the patient that they would be willing to undergo cataract surgery if it is offered?	Yes / No *(delete)*

*** Remember - as a general rule do not refer if patient's VA is better than 6/12**

Additional information from GP: Please attach or insert current medication list

White Copy to GP for forwarding to clinic	Yellow Copy for GP Medical Records	Blue Copy for Optometrist Clinical Records

LPC 07/13/024