

**Post Capsular Opacification and YAG Laser Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | | | | | | | | | | | | | | | | | |
| **Title** (Dr, Mr, Mrs, Miss, Ms) | **Surname** | | | | | | | **Other Names** | | | | | | | | | | | | | |
| **Address**  **Post Code** | | | | | | | | **DOB** | |  | | | | | | | | | | | |
| **TEL No** | |  | | | | | | | | | | | |
| **HOSP No** | |  | | | | | | | | | | | |
| **NHS No** | |  | | | | | | | | | | | |
| **Details of Posterior Capsular Opacification (PCO)** | | | | | | | | | | | | | | | | | | | | | |
| **PCO is present in** (please circle) | | | | | | | | **RE** | | | | | | | | **LE** | | | | | |
| **Details of Visual Acuity (Corrected)** | | | | | | | | | | | | | | | | | | | | | |
|  | **Date** | | | | | | | **RE** | | | | | | | | | **LE** | | | | |
| **Current VA** |  | | | | | | |  | | | | | | | | |  | | | | |
| **Maximum Previous VA**  (if known) |  | | | | | | |  | | | | | | | | |  | | | | |
| **Maximum Post-operative VA** (if known) |  | | | | | | |  | | | | | | | | |  | | | | |
| **Other Clinical Findings** | | | | | | | | | | | | | | | | | | | | | |
|  | **RE** | | | | | | | | | **LE** | | | | | | | | | | | |
| **Lens status** (please circle) | Normal | | Cataract | | | IOL | | | Aphakia | Normal | | | | | Cataract | | | IOL | Aphakia | | |
| **Intraocular Pressure** | mmHg | | | | | | | | | mmHg | | | | | | | | | | | |
| **Ocular co-morbidity** |  | | | | | | | | |  | | | | | | | | | | | |
| **Any History of** (please tick) | **Retinal Detachment** | | | |  | | **Glaucoma** | | | | |  | | **High Myopia** | | | | | |  | |
| **Does the patient have symptoms as a result of PCO?** (Please tick) | **Yes** | | | |  | | **No** | | | | |  | |  | | | | | |  | |
| **Patient wants YAG laser Capsulotomy if offered?** (Please tick) | **Yes** | | | |  | | **No** | | | | |  | | **Unsure** | | | | | |  | |
| **Additional Comments** | | | | | | | | | | | | | | | | | | | | | |
| **Name and Address of GP** | | | | | | | | **Name and Address of Optometrist** | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | |
| Anglia Community Eye Service | |  | | BMI Healthcare Sandringham | | | | | | |  | | Queen Elizabeth Hospital | | | | | | | |  |

**SEND TO – West Norfolk Health, Referral Support Service, King’s Court, Chapel Street, King’s Lynn, Norfolk, PE30 1EL** (Jan 2019)