

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

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|  **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)