|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Norfolk & Norwich University Hospitals NHS Foundation TrustPosterior Capsular Opacification Direct Referral Form | | | | | | | | | | | | | | | | | |
| Email direct to the NNUH Outpatient Booking Team: [OPServicesPostTeam@nnuh.nhs.uk](mailto:OPServicesPostTeam@nnuh.nhs.uk)NB Email only from an NHSmail address (ending @nhs.net) | One referral only per email | | | | | | | | | | | | | | | | | |
|  | | | | | Patient Details | | | | | | | | | |  | | |
| Title (Dr Mr Mrs Miss Ms) | | | Surname | | | | | | | | Other Names | | | | | | |
| Address | | | | | | | | | |  | | | | | | | DoB: |
| Phone: |
| Post Code | | | | | | | Hosp No: |
| Details of Posterior Capsular Opacification (PCO) | | | | | | | | | | | | | | | | | |
| PCO is present in which eye?: | | | | | | RE | | | | | | LE | | | | |  |
| Details of Visual Acuity (Corrected) | | | | | | | | | | | | | | | | | |
|  | | | | | | RE | | | | | | LE | | | | | Date |
| Current VA: | | | | | |  | | | | | |  | | | | |  |
| Maximum Previous VA (if known): | | | | | |  | | | | | |  | | | | |  |
| Maximum Post-operative VA (if known): | | | | | |  | | | | | |  | | | | |  |
| Other Clinical Findings | | | | | | | | | | | | | | | | | |
|  | | | | RE | | | | | | | | | | LE | | | |
| Lens status: | | | |  | | | | | | | | | |  | | | |
| Intraocular Pressure: | | | | mmHg | | | | | | | | | | mmHg | | | |
| Ocular co-morbidity: | | | |  | | | | | | | | | |  | | | |
| Any history of: | | | | Retinal Detachment | | | | | Glaucoma | | | | | | | High Myopia | |
| Does the patient have symptoms as a result of PCO? | | | | | | | | Yes  No | | | | | | | | | |
| Patient wants YAG laser capsulotomy if offered?: | | | | | | | | Yes  No  Unsure | | | | | | | | | |
| Preferred location for appointment: | | | | | | | | Norwich  Cromer | | | | | | | | | |
| Additional Comments: | | | |  | | | | | | | | | | | | | |
| Optometrist: | | Name: | | | | | | | | | | | GOC No:       Date: | | | | |
| Name & Address of GP |  | | | | | | Name & Address of Optometrist | | | | | |  | | | | |
| ***Email one copy to NNUH One copy to GP for information only*** | | | | | | | | | | | | | | | | | |