**NORFOLK & WAVENEY CATARACT REFERRAL FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Names** |  | | |
| **Surname** |  | | |
| **Address** |  | | |
| **Postcode** |  | | |
| **DaytimeTel No.** |  | | |
| **Date of Birth** |  | **NHS Number** |  |
| **GP Practice** |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **First Cataract** | | | | | |  | **Second Cataract** | | | | |
| **Prescription details from current sight test** | | | | | | **Date:** |  | | | | | |
|  | **Unaided Vision** | **Sph** | **Cyl** | **Axis** | **Prism** | **Base** | **Best corrected VA** | | **Add** | **Near  V/A** | **Previous corrected VA** | |
| **Date** |  |
| **R**  **E** |  |  |  |  |  |  |  | |  |  | **RE** | |
| **L**  **E** |  |  |  |  |  |  |  | |  |  | **LE** | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **RE** | | **LE** | |
| Disc Appearance |  | |  | |
| Intra-Ocular 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.  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](about:blank) | | | | | | | | | |
| **Description of cataract and any known co-morbidities:** | | | | | | | | | |
| **Any other factors for approving cataract surgery (please check all that apply):** | | | | | | | | | |
|  | **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:** | | | | |
| **I confirm that this patient meets the NWICB cataract surgery referral criteria, and indicated above** | | | | | | | | |  |
| **Name and Address of Optometrist/OMP** | | | |  | | | | | |

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| **Medical History** |
| The following information is required.  Please include details of   * Previous medical history: * Current medication, * BMI, * Blood Pressure, * Allergies.   **Please note**: Routine blood results not required unless they were undertaken within the last 6 months. Up to date HbA1c required for diabetic patients.  To provide this information as per locally agreed process directly to the provider below. |
| Your patient has chosen the provider below: |

**SEND TO**

**Great Yarmouth and Waveney**

Please ensure the service user is offered Patient Choice and send referral directly to service user’s preferred provider.

**West Norfolk**

Send referral form to : [nwicb.wnophthalmology@nhs.net](about:blank)

West Norfolk Health, NHS Referral Support Service,QEH,Gayton Road,Kings Lynn PE30 4ET

***Note:*** *Please DO NOT send a copy to GP Practice or direct to Provider as this causes duplicate referrals*

**Norwich, North Norfolk ,South Norfolk**

Send referral form to : [nwicb.snh@nhs.net](about:blank).

Norfolk Cataract Referral Service, South Healthcare CIC, The Chapel, Keswick Hall, Norwich NR4 6TJ.

***Note:*** *Emails not from an NHS mail account will be rejected. Please do NOT email or post a copy to the GP. The cataract service will notify the patient’s GP*