RCCG Cataract Assessment / Referral Form

NHS Rotherham Clinical Commissioning Group

GP Name:	……	**Patient Surname:**	…… Title:……..
Address:	……	Forename(s):	……
	……	Date of Birth:	……
Postcode:	…… Tel: ……	Address:	……
Optometrist Name:	……		……
Address:	……	Postcode:	……
Postcode:	……Tel: ……	Tel 1:	…… Tel 2:……

VA Scores VA 6/6 = 0 VA 6/9 = 1 VA 6-12 = 2 VA 6/18 and below = 7		**SPH**	**CYL**	**AXS**	**VA**	**Dominant Eye**	**Score**	
	R							**VA Score**
	L							

Lifestyle Questions to ask a Patient	**Not at all**	**Slightly**	**Moderately**	**Very Much**
Is the patient's quality of life affected by vision difficulties (*e.g. car driving, watching TV, doing hobbies etc*)?				
Is the patient's social functioning affected by vision difficulties (*e.g. crossing roads, recognising people, recognising coins etc*)?				

Please circle	**Yes**	**No**
Any difficulties for patient with mobility *(including aspect of travel e.g. driving, using buses)*?	2	0
Is the patient affected by glare in sunlight or night *(car headlights)*?	2	0
Is patient's vision affecting their ability to carry out daily tasks?	2	0

TOTAL ASSESSMENT SCORE (VA AND LIFESTYLE SCORE) ☐

☐ Patient Requires Referral ☐ Patient Doesn't Require Referral

Referred to (name of provider): ……

☐ Refer for surgical assessment ☐ Previous Refractive Surgery?

Referred to (name of provider): ……

Important: A patient with a total assessment score of 7 and over should be referred, unless you have indicated reasons below for not referring. A patient with a total assessment of under 7 should be advised that a referral for a cataract operation is not essential at this time. The patient should be advised to return for a further assessment as and when you see fit. If the patient has a score of less than 7 but you feel referral is still required please state why.

Previous stable refraction prior to cataract development (if available and if referring):

	SPH	**CYL**	**AXS**	**VA**		**SPH**	**CYL**	**AXS**	**VA**	**DATE**
R					**L**					

Reasons for Non / Referral, Comment, Ocular Pathology:

Interpreter required? No Yes Language: ……

I understand that I am being referred for surgical assessment and I have received an information leaflet explaining this. Furthermore, I am willing to consider surgery if this is felt necessary.

Patients Signature: …… **Date:** ……

Signed:
(Optometrist/OMP) …… **Referral date:** …….. **GOC/GMC No**: ……

Copy 1: To The Rotherham Foundation Trust or GP for referral
Copy 2: To Patients GP
Copy 3: Primary Care Team at Rotherham CCG, Oak House, Moorhead Way, Bramley S66 1YY
Copy 4: Optometrists file copy
(Where TRFT are not the centre of choice for referral please give the patient a copy of this form)