OPEN ACCESS GENERIC REFERRAL FORM

PLEASE FAX: 0161 835 1704 / 0161 839 1423 or EMAIL: spamedica.referrals@nhs.net (secure only from an NHS.net account)

1. **Referring for: Cataract Surgery □ / YAG Capsulotomy □**
2. **Patient choice of SpaMedica hospital: Manchester□ / Newton□ / Bolton□ / Wirral□ / Liverpool□ / Wakefield□ / Sheffield□ / Birmingham□**
3. **Transport Required? Yes□ / No□** (Must be mobile and live within 10-30 miles of SpaMedica. Appointments within 2 weeks cannot be guaranteed with transport)
4. **Optom post-operative assessment? Yes□ / No□** (On selecting 'Yes' you are indicating yourself or another within the practice is accredited by SpaMedica and will perform the cataract post-op assessment (name)
5. **Patient consent for SpaMedica to obtain medical summary:** I give consent for my GP to release my medical summary to SpaMedica (Patient signature)

Section 1 - to be completed by Optometrist

Name:	**GP's Name:**	**Optometrist's Name:**
Date of Birth:		
Address:	**Address:**	**Address:**
Post Code:	**Post Code:**	**Post Code:**
Tel No:	**Tel No:**	**Fax No:**
		Tel No:

I have explained the benefits and risks of surgery: **Yes□ / No□ / N/A□**

The patient wants surgery: **Yes□ / No□ / N/A□**

The patient has significantly impaired visual function: **Yes□ / No□ / N/A□**

		SPh	Cyl	Axis	Prism	Add	VA	Near	IOP AT/ NCT
Previous refraction	**R**								**Mm/Hg**
Date	**L**								**Mm/Hg**
Current refraction	**R**								**Mm/Hg**
Date	**L**								**Mm/Hg**

Lens R Clear□ Nuc□ Cor□ PSC□	**Lens L** Clear□ Nuc□ Cor□ PSC□

Cornea R □ Healthy □ L

Macula R □ Healthy □ L Comments

Discs R □ Healthy □ L **Pupils dilated Yes □ No □**

Squint□ / Amblyopia□ / Other□ Comments

Patient requires interpreter Yes□ / No□ Language:

Please tick for any quality of life or independence lifestyle issues caused by cataract: Driving □Work □ Binocular Vision □ Cooking □ Shopping □ Mobility □ Independence □Special Visual Needs □ Reading □Giving Care □ Other Disabilities □

Other/Comments

Signature: Print Name: Date:

Section 2 – To be completed if felt appropriate by General Medical Practitioner

Further Clinical Details:

Signature: Date: