Post Cataract Assessment Form

If you are unable to use our community optometrist portal, please complete this manual form and fax to 0161 835 1704 or 0161 839 1423 (both secure fax lines)

Patient Details

Patient Name	
DOB	
NHS Number	

Date of assessment

DD	MM	YY

Visual Acuity

Right		Left	
Unaided	6/	Unaided	6/
Best Corrected VA	6/	Best Corrected VA	6/
Near VA	N	Near VA	N

Refraction

Right				Left			
Sph	Cyl	Axis	Add	Sph	Cyl	Axis	Add
	+				+		

Intra Occular Pressure

Recorded with Goldman/Non Contact/Perkins/Tonopen/I Care *(Please Select)*

Right	Left
mm Hg	mm Hg

Examination

Right				Left	
No to all □				No to all □	
Yes □	No □	Unclear Cornea		Yes □	No □
Yes □	No □	Active Anterior Chamber		Yes □	No □
Yes □	No □	Peaked Pupil		Yes □	No □
Yes □	No □	Displaced IOL		Yes □	No □
Yes □	No □	Iris Trauma		Yes □	No □
Yes □	No □	Iris Prolapse		Yes □	No □
Yes □	No □	CMO		Yes □	No □
Yes □	No □	Wet AMD		Yes □	No □
Yes □	No □	Dry AMD		Yes □	No □
Yes □	No □	Other		Yes □	No □

Comments

Patient Questions *(Please Select)*

I am satisfied with my visual outcome following surgery	Strongly Agree/Agree/Neutral/Disagree/Strongly Disagree
I am satisfied with my experience today with my optometrist	Strongly Agree/Agree/Neutral/Disagree/Strongly Disagree
I would recommend SpaMedica to Friends and Family	Strongly Agree/Agree/Neutral/Disagree/Strongly Disagree

Outcome

No Further Action	Yes □
Refer for 2nd Eye	Yes □
Hospital Review - Routine	Yes □
Hospital Review - Urgent	Yes □
Assess for YAG	Yes □

Practice Stamp