SpaMedica

OPEN ACCESS GENERIC REFERRAL FORM

NHS

PLEASE FAX: 01204 441340 or EMAIL: spamedica.referrals@nhs.net (secure only from an NHS.net account)

1. **Referring for: Cataract Surgery ☐ / YAG Capsulotomy ☐ Referral For: Right☐ Left☐ Both☐**
2. **After an informed conversation with this patient, they have chosen SpaMedica as their provider of choice ☐**
3. **Transport Required? Yes☐ / No☐** (Must be mobile and live over 10 miles from 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:

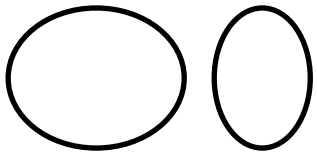
I have explained the benefits and risks of surgery: Yes☐ / No☐ / N/A☐

The patient wants surgery: Yes☐ / No☐ / N/A☐

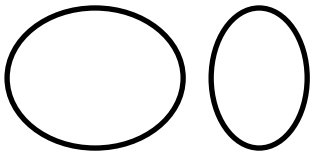
The patient has significantly impaired visual function: Yes☐ / No☐ / N/A☐

		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: _____