CENTRAL NORFOLK CATARACT REFERRAL SERVICE / CATARACT REFERRAL FORM

***Surname** (Dr, Mr, Mrs, Miss, Ms) ***Forename(s)**	***Name and Address of GP Practice (including postcode)**
*Address	
*Postcode	*Name and Address of Optometrist/OMP (including postcode)
***DOB** *NHS Number if known	
*Daytime Telephone	

Prescription details from current sight test										***First or Second Cataract (please circle)**
*	Uncorrected Vision	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA	Previous corrected VA Date
RE										RE
LE										LE

Disc appearance:

RE.....LE.....

Intra –Ocular Pressure: RE.....mmHg LE.....mmHg Pneumo/Applanation Tonometer

Description of cataract and any known co-morbities / additional comments:

Any other factors for approving cataract surgery **(please circle)**

Diabetes / Driving Related / Glaucoma / Occupation requiring good vision e.g. detailed reading, watch repair etc / Subcapsular/Nuclear/Glare (see Knowledge Anglia website):

www.knowledgeanglia.nhs.uk/KMS/GreatYarmouthandWaveney/Home/ClinicalThresholdsPolicy/A-D/CataractSurgery.aspx

*Name of Optometrist (print): Signed (Optometrist): Date:

This Section to be signed by the GP and sent on to the Ophthalmic Screening Co-ordinator. **You may choose to attach: Previous Medical History/Current Medication/BMI/BP/Smoking Status/Allergies and any other relevant medical records**

Any other relevant clinical history to note:	Your patient has chosen the below provider:
* Signed (GP): Date:	

Copies to be sent to Central Norfolk Cataract Referral Service, West Site C, Norwich Research Park, Norwich, NR4 7UT