

Direct Referral for Cataract Surgery

Patient details:

Title Firstname Surname

Date of Birth Telephone

Address

Postcode

Optometrist details:

Name

Address

Postcode

Telephone

Email

General practitioner details:

Name

Address

Postcode

Telephone

Email

Optometrist's information:

| Right eye | | | | Left eye | | | | |
|---|----------------------|--------------------------------|----------------------|-----------------------------------|----------|----------------------|------|----------------------|
| Distance | <input type="text"/> | Near | <input type="text"/> | Visual acuity | Distance | <input type="text"/> | Near | <input type="text"/> |
| Sph | <input type="text"/> | Cyl | <input type="text"/> | Refraction | Sph | <input type="text"/> | Cyl | <input type="text"/> |
| | <input type="text"/> | Axis | <input type="text"/> | Examination findings | | <input type="text"/> | Axis | <input type="text"/> |
| <input type="text"/> | | | | <input type="text"/> | | | | |
| Suggested planned refractive outcome <input type="text"/> | | | | Dominant eye <input type="text"/> | | | | |
| Suggested lens implant (please delete) <input type="text"/> | | | | | | | | |
| Referring Optometrist <input type="text"/> | | Signature <input type="text"/> | | Date <input type="text"/> | | | | |

Clinical information from GP:

Medical history

Diabetes

High blood pressure

Heart disease

Other

Medication

Referring GP Signature Date