Newmedica

Community Ophthalmology Referral Form

Bristol, South Gloucestershire and North Somerset CCGs

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Patient Name:	**GP Name:**	**Optometrist Name:**
DOB:	**Address:**	**Address:**
Address:		
Postcode:	**Postcode:**	**Postcode:**
Contact Number:	**Contact Number:**	**Contact Number:**

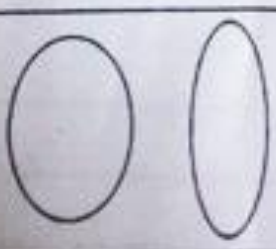
Please tick:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ YAG
- ☐ General
- ☐ Medical Retina
  - Excluding: Macular
  - Excluding: Macular Conditions

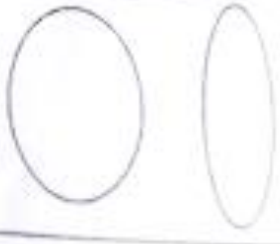
I have explained the benefits and risks of cataract surgery
Yes / No / N/A
The patient wants cataract surgery:
Yes / No / N/A
The patient has significantly impaired visual function:
Yes / No

		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



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Cornea	R ☐ Healthy ☐ L	Comments:
Macula	R ☐ Healthy ☐ L	Pupils dilated
Disc	R ☐ Healthy ☐ L	Size ____ mm
Squint / Amblyopia / Other		Comment:

Additional Information:

Patient Offered Choice of Provider?	Yes No
Patient aware of choice	Sign:
GOS18 included	Yes No
Patient Requires an Interpreter	Yes No Language:
Is the Patient a Driver	Yes No
Has the patient got special visual needs	Yes No
Notes	

Signature _____

Date _____

Name: _____