**DIRECT CATARACT REFERRAL FORM**

**Please note that referrals relevant to this form should go via the Choice Office reflecting the requirements of the North Yorkshire/Vale of York CCGs Cataract Commissioning Statement and not be for the identified excluded patients.**

**DATE OF REFERRAL / / \_**

**(Is this as a result of a follow-up assessment? Y/N)**

VISUAL ACUITY

**Patient Choice Office Referral Management Service**

West Offices, Station Rise

York, YO1 6GA

Telephone: 0300 3030060

Practice Stamp

 Patient Name DOB **/ / \_**

Address

Telephone NHS Number

GP Name and Surgery

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Surgery required on: | Tick appropriate boxes - | First eye |  | Second eye |  | Right eye |  | Left eye |  |

**VISUAL ACUITY**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Unaided VA | Sphere | Cyl | Axis | Prism | Base | New VA | Add | Near VA | Previous Corrected VA:Date: |
| RE |  |  |  |  |  |  |  |  |  |
| LE |  |  |  |  |  |  |  |  |  |

**Total Visual Acuity ‘score’ for this patient** (i.e. add the scores for both eyes as below) (VA of 6/6 and 6/4 = score of ‘0’, VA of 6/9= ‘1’, VA of 6/12= ‘2’, VA of 6/18= ‘3’, VA worse than 6/18= ‘10’)

**LIFESTYLE QUESTIONS TO THE PATIENT**

Does the patient have any difficulty with mobility (including all aspects of travel, e.g. driving, using buses)?

**Score ‘2’ for ‘yes’ and ‘0’ for ‘no’**

Is the patient affected by glare in sunlight or at night (e.g. car headlights)?

**Score ‘1’ for ‘yes’ and ‘0’ for ‘no’**

Is the patient’s quality of life affected by vision difficulties (e.g. car driving, watching TV, doing hobbies, etc)?

**Score ‘3’ for ‘very much’, ‘2’ for ‘moderately’, ‘1’ for ‘slightly’, ‘0’ for ‘not at all’**

Is the patient’s ‘social functioning’ affected by vision difficulties (e.g. crossing roads, recognising people, recognising coins, etc)?

**Score ‘3’ for ‘very much’, ‘2’ for ‘moderately’, ‘1’ for ‘slightly’, ‘0’ for ‘not at all’**

Is the patient’s vision affecting their ability to carry out daily tasks?

**Score ‘2’ for ‘yes’ and ‘0’ for ‘no’**

**TOTAL ASSESSMENT SCORE (VA SCORE PLUS LIFESTYLE SCORE)**

***Important***

*A patient with a total assessment score of 10 and over should be referred, unless you have indicated reasons below for not referring.* ***Please provide description of cataract and any known co-morbidities below.***

*A patient with a total assessment score of under 10 should be advised that a referral for a cataract operation is not essential at this time – the patient should be advised to have a follow-up assessment in 6 months. If the patient has a score of less than 10 but you feel a referral is still required, please state why.*

*............................................................................................................................................................................................*

*............................................................................................................................................................................................*

**I claim payment as per the Direct Cataract Referral Scheme. To be completed by the contractor or authorised signatory:**

**Signature:……………………………………. Date:……………………………………….**