**BNSSG – Cataract Referral Form**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Urgent  Routine**  **Please tick if there are any issues regarding consent for this patient - if there are then please provide details and check exclusions /advise provider in this referral to assist with best interest planning** | | | | | | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | |  | | | | | | | **Referrer details** | | |  | **Patient details** | | | | | | | Date of referral |  |  |  | Name |  | | | |  | | Practice name |  |  |  |  |  | | | |  | | GP Name / Number |  |  |  | Address |  | | | |  | | Referring GP |  |  |  |  |  | | | |  | | CCG name | BNSSG CCG |  |  | Postcode |  | | | |  | | Practice address |  |  |  | Telephone |  | | | |  | |  |  |  | Date of Birth |  | NHS no | |  |  | | Telephone |  |  |  | Gender |  | Ethnicity | |  |  | | Fax |  |  |  | Height cm |  | Weight kg | |  |  | | Email address |  |  |  | Transport required | Yes | No | | |  | | **Please complete if not the patient’s regular GP** | |  |  | Transport requirements |  | | | |  | | Name of patient’s GP |  |  |  | Interpreter required | Yes | | No | |  | | Name of GP practice |  |  |  | Interpreter requirements |  | | | |  | |  |  |  |  |  |  | | | |  | |  | | | | | | | | | | | | | | | | |
|  | | | |  | | |
|  | | | | | | |
| Please refer to cataract guideline referral: <https://bnssgccg.nhs.uk/individual-funding-requests-ifr/individual-funding-requests-directory/cataract-referral/> | | | | | | |
| **RELEVANT HISTORY AND RECENT MANAGEMENT**   |  | | --- | |  | | | | | | | |
| |  |  |  | | --- | --- | --- | |  |  |  | |  | **Date obtained** | **Result** | | BMI |  |  | | Blood Pressure |  |  | | eGFR |  |  | | HbA1c |  |  |   **Further Information Required**  Computerised summary outlining current medical history, medication and allergies (Please tick and attach, or referral may be  returned)  Patient is Diabetic - Please give details of management (insulin/oral/medication/diet)  A history of previous ophthalmic problems/procedures (Please tick if attached)  Current use of anti-coagulants / anti-platelets | | | | | | |
|  | | | | | | |
| **Referral requirements for day case procedure** | | | | | | |
| There are some differences between providers regarding suitability for day case procedure but these may include the following:   * Escorted home following procedure * Accompanied at home for 24 hrs. following procedure * Access to telephone at home | | | | | | |
| **Signed by referring clinician:** |  | | | | **Date:** |  |
|  |  |  |  | |  |  |
| (If computer generated referral – please insert name and date here, adding your name, dating and sending this referral indicates your consent to the terms of this referral) | | | | | | |
|  | |  |  | | | |
| If you have any questions about your referral then please go to the Cataract section of Remedy which includes contact details of the provider if you wish to contact them directly to discuss your referral. | | | | | | |