

# T11b Cataract Surgery (Secondary care referral)



Patient Name:  
 Address:  
 Date of Birth:  
 NHS Number:  
 Hosp of choice

evolutio Ltd  
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 Newtown Road  
 Henley on Thames  
 Oxfordshire RG9 1HG

Fax: 0333 240 7729

### Part 3 – Exceptions for second eye surgery To be completed by Hospital Clinicians only

Anisometropia - refractive difference between the two eyes ( $\geq 3$ ) resulting in poor binocular vision or disabling diplopia which may increase the risk of falls	<input type="checkbox"/>
Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma	<input type="checkbox"/>
Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management.	<input type="checkbox"/>
Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery	<input type="checkbox"/>
Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)	<input type="checkbox"/>
Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis)	<input type="checkbox"/>
Other glaucoma's, inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography	<input type="checkbox"/>
Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes)	<input type="checkbox"/>

Surgery required on: (Please circle/delete)	First/second eye	Right/Left Eye
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**Hospital Clinician Use Only:**  
 Please complete the following and log/file for future compliance audit.

Referral criteria are met and the patient will benefit from the proposed treatment: Y N

Clinician Signature.....

Estimated date of treatment: \_\_\_/\_\_\_/\_\_\_

Please print name of Consultant Lead for Clinic:

**For Commissioners Use:**

Criteria met as per policy Y N  
 Audit date: \_\_\_/\_\_\_/\_\_\_

Compliance with notes Y N  
 Audit date: \_\_\_/\_\_\_/\_\_\_  
 (Optom/Cons)