Practice Plus Group

Practice Plus Group Surgical Centre, Gillingham

Cataract Surgery

Date: / /

Referring Practice	Patient's GP	Patient information
	DR.	Name:
		Gender: Male ☐ Female ☐
	Practice address:	DOB: Height: Weight:
		NHS number
		Telephone number
		Mobile number Address:
		Postcode:

Examination findings:

	Right	Left
Visual Acuity		
Refraction		
Cataract Found	Yes / No	
Lids		
Cornea	Clear	Clear
Anterior Chamber Depth	Narrow / Deep	Narrow / Deep
IOP		
Optic Disc		
Macula		
Periphery		

Please summarise any relevant medical history. (including details of past vitrectomy, co-morbidities and anaesthesia history):

Current medication:

Allergies (general & medication)

Any other comments:

Special requirements:
☐ Interpreter - language:
☐ Signer ☐ Hearing devices
☐ Transport - entitled to PTS? ☐ Yes ☐ No

I confirm that the above named patient is visually disabled by symptoms of Cataract and would like to be considered for Cataract Surgery. Please refer to our website for details of our exclusion criteria.

Signature of referring practitioner: ____________________

Please email practiceplusgroupgillingham@nhs.net or post to:
The Bookings Team, Practice Plus Group Surgical Centre, Gillingham, Beechings Way, Gillingham ME8 6AD