CATARACT POST-OP ASSESSMENT (4 weeks)

Date of review ______________________

PATIENT DETAILS:

Title: __________ First Name: __________________________ Surname: ____________________________

Date of Birth: ________________ NHS Number: ________________

Address: ____ Postcode: __________

Mobile Phone No.: _______________________ Home Phone No.: ____________________________

GP Name & Address: ____ Postcode: __________

CLINICAL DETAILS:

Date of Procedure: ______________ Consultant Name: ______________________________________

Address: ____

Which eye was treated? ☐ Right Eye ☐ Left Eye

IOP: R _____ L _____ ☐ Goldman ☐ Perkins ☐ iCare ☐ NCT

Pain ☐ No ☐ R ☐ L ☐ Both
Unexplained reduced VA ☐ No ☐ R ☐ L ☐ Both
A/C cells ☐ No ☐ R ☐ L ☐ Both
Posterior synechiae ☐ No ☐ R ☐ L ☐ Both
Vitreous activity ☐ No ☐ R ☐ L ☐ Both

Incision not healing/abnormal ☐ No ☐ R ☐ L ☐ Both
Reduced corneal clarity ☐ No ☐ R ☐ L ☐ Both
Posterior capsular thickening ☐ No ☐ R ☐ L ☐ Both
Intolerable refractive error ☐ No ☐ R ☐ L ☐ Both

What is the refractive error and VA?

	Sph	Cyl	Axis	VA	Add	Near VA
Right:						
Left:						

Any additional relevant information?

Patient is: ☐ Satisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied (tick one with supporting comments)

Plan:
☐ Discharge
☐ Optometrist Review / Follow-up (specify timescale: _________________________)
☐ Refer back to ophthalmologist for complication related to surgery*
☐ Refer to ophthalmologist for a condition unrelated to recent cataract surgery*

* NB This form does NOT constitute a referral - a separate referral must be made with appropriate urgency

CLINICIAN DETAILS:

First Name: __________________________ Surname: ____________________________

GOC: ________________

Practice Address: ____ Postcode: __________

Email Address: ______________________________ Phone Number: ______________________