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	Incision not healing/abnormal	☐ No ☐ R ☐ L ☐ Both
Unexplained reduced VA	☐ No ☐ R ☐ L ☐ Both	Reduced corneal clarity	☐ No ☐ R ☐ L ☐ Both
A/C cells	☐ No ☐ R ☐ L ☐ Both	Posterior capsular thickening	☐ No ☐ R ☐ L ☐ Both
Posterior synechiae	☐ No ☐ R ☐ L ☐ Both	Intolerable refractive error	☐ No ☐ R ☐ L ☐ Both
Vitreous activity	☐ No ☐ R ☐ L ☐ Both		

What is the refractive error and VA?

Right:						
	Sph	Cyl	Axis	VA	Add	Near VA
Left:						

Any additional relevant information?

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

Vision is: ☐ Improved ☐ No Change ☐ Worse

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: _____