NHS
Derby and Derbyshire
Clinical Commissioning Group

Derbyshire PLCV Referral Form – Optometrists for Cataract Surgery (1st and/or 2nd eye)

Name of Referring Optometrist:	
Name and Address of Optom's Practice	
Contact Telephone No:	

Patient details	
Surname	
Forename(s)	
Date of birth	
NHS Number	
GP Practice	

Patient Consent	
	Mark or tick boxes below to confirm
By submitting this request you are confirming that you have reviewed this request against relevant policy and believe the patient meets the relevant threshold criteria and therefore you have fully explained to the patient the proposed treatment and they have consented to you raising this referral on their behalf.	☐
Part A - PLCV Criteria	**At least ONE must apply**
First Eye Cataract surgery will be funded where the visual acuity after refractive correction is 6/9 or worse in the worst eye (the eye to be treated)	☐
OR the patient has one of the following (with correction):	**At least ONE must apply**
Reduced mobility, experiencing difficulties in driving, for example, due to glare, or experiencing difficulty with steps or uneven ground. Ability to work, give care or live independently is affected	☐
The patient has diabetes, or retinal condition, and requires clear views of their retina to monitor their disease or treatment	☐
The patient has glaucoma and requires cataract surgery to control the intra ocular pressure	☐
The patient has posterior subcapsular or cortical cataracts and experiences problems with glare and a reduction in acuity in bright conditions	☐
The patient'svisual field defects are borderline for driving, and cataract extraction would be expected to significantly improve the visual field	☐

Cataract surgery in the second eye will ONLY be funded if:	At Least ONE must apply
The first does not achieve an acuity of 6/9 or better, with refractive correction, and the procedure is clinically indicated for the patient's individual circumstances.	☐
The patient has diabetes, or retinal condition, and requires clear views of their retina to monitor their disease or treatment.	☐
The patient has glaucoma and requires cataract surgery to control the intra ocular pressure.	☐
There is, after first eye operation, resultant anisometropia (a large refractive difference between the two eyes) which would result in diplopia (double vision)	☐
An uncorrectable loss of acuity in the second eye (with first eye corrected) that effectively renders the second eye vision worse than 6/24.	☐
This information, together with a report from a recent sight test, should form the minimum data on the referral form.	

Additional Patient Information	BOTH must apply
This patient is willing to undergo a surgical procedure should it be offered.	☐
I have discussed with the patient the fact they will be referred for a possible procedure but there is no guarantee that a surgical intervention will be the required outcome following the consultation with the secondary care specialist.	☐

Prior Approval No : **(added by Secondary Care Provider)**	

Secondary Care Provider	
Name of Hospital where referral will be sent	

I confirm that the patient meets the current clinical guideline/policy for referral for the procedure.

Name of referrer: _____ Date: _____

Please note any individual patient requirements here (e.g. Wheelchair user).

THIS FORM MUST BE COMPLETED AND SUBMITTED WITH THE:

- **GOS REFERRAL FORM** ☐