NHS
Derby and Derbyshire
Clinical Commissioning Group

Derbyshire PLCV Referral Form

Cataract Surgery (1st and/or 2nd eye)

THIS FORM MUST BE COMPLETED IN FULL AND SUBMITTED WITH THE APPROPRIATE CLINICAL INFORMATION

Patient details
Surname
Forename(s)
Address Post code
Date of birth
NHS Number

Referring GP details
Referring GP
Practice name
Practice address
Telephone number
GP practice code

Patient Consent	
	Mark or tick boxes below to confirm
I confirm the patient has consented to sharing personal and clinical information contained within this referral form. The Derbyshire Prior Approval Team will process this information, clarify data and communicate with the patient and the GP on the outcome.	☐
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.	☐
Please confirm that you have given PLCV patient leaflet to the patient	☐

Part A - PLCV Criteria	At least ONE must apply
First Eye Cataract surgery will be funded where the visual acuity after refractive correction is worse than 6/9 or worse in the worst eye (the eye to be treated)	☐
OR the patient has one of the following (with correction):	
Reduced mobility, experiencing difficulties in driving, for example, due to glare, or experiencing difficulty with steps or uneven ground or the ability to work, give care or live independantly.	☐
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 intraocular pressure.	☐
The patient has posterior subcapsular or cortical cataracts and experiences problems with glare and a reduction in acuity in bright conditions.	☐
The patient's visual field defects are borderline for driving, and cataract extraction would be expected to significantly improve the visual field.	☐
This information, together with a report from a recent sight test, should form the minimum data on the referral form.	
Second Eye Cataract surgery will **NOT** be funded in the second eye if the first eye has achieved a visual acuity of 6/9 or better, with refractive correction, and the acuity of the second eye is 6/24 or better with refractive correction. These patients should be reviewed by their optometrist annually or earlier if there is any deterioration in vision.	
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.	

Free Text Box Additional clinical information that may have a bearing on the application

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 :	

Patient Choice of Provider	
First Choice:	[Manually enter provider name]
Second Choice:	[Manually enter provider name]

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

Name of referrer: _____ Date: _____

Part B – Reason for referral	
Salutations: Preamble/context:	Dear colleague, ${Current_Consultation} Thank you, ${Referring_doctor}

Problems

${Major_Active_Problems}

${Minor_Active_Problems}

Relevant SH & FH:

Date Smoking status Alcohol Occupation Ethnicity Veteran? Detail which might assist timely discharge:	${Todays_date} ${RC_137..} ${RC_136..} ${RC_0....} ${RC_9i...} ${RC_13Ji.}

Medication – ${Todays_date}

${Current_Acute_Issues}

Allergies – ${Todays_date}

${Allergies}

Useful values:

BP ${RC_246..} **Systolic BP** ${RC_2469.} **Diastolic BP** ${RC_246A.} ${Todays_date}	**Pulse rate** ${RC_242..}	**Height** ${RC_229..}	**Weight** ${RC_22A..}	**BMI** ${RC_22K..}	**HbA1C** ${RC_42W..} ${Todays_date}

Please embed any attached items here.

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