Quality surgery in the community

Norwich & Norfolk Surgical Ltd
St Stephens Gate Medical Practice
55 Wessex Street Norwich NR2 2TJ

POSTERIOR CAPSULAR OPACIFICATION
REFERRAL FORM

PATIENT DETAILS

Please complete information in full, inc. mobile number and email address

Title:		Surname:		Forename(s):	
Address:				Date of Birth:	
NHS NO				Postcode:	
Mobile:		Phone:		Email:	

DETAILS OF PATIENT'S VISUAL SYMPTOMS

Please complete information in full, including anything you think is relevant

Significant PCO is present in:	RE ☐ LE ☐	Comments:	

Current Rx	Sph	Cyl	Axis	Prism	Add	BCVA	Near VA
R							
L							

	RE	LE	Comments:
Maximum Previous VA:			
Maximum Post-op VA:			
Date of Cataract Surgery:			
Intraocular Pressure:			
Ocular Co-morbidity:			

Any regular eye medication:	Please include details of any medication/drops for ocular conditions, such as Glaucoma etc.		
Any history of:	Retinal Detachment ☐	Glaucoma ☐	High Myopia ☐
Date of Sight Test:		Date of Referral (if different):	

DETAILS OF PATIENT'S HEALTH AND LIFESTYLE

Please be as detailed as possible to ensure the safety of the patient in our facility

Significant Health Issues:			
Mobility/memory issues:		Allergies:	
Additional comments:	eg. interpreter required and language, patient requires assistance with drops etc.		

DETAILS OF PROFESSIONALS

Please gather the correct GP details from the patient, to ensure they're in our catchment area

Optometrist Name:		Named GP:	
GOC Number:		GP Practice:	
Practice Name and Address:		Address:	

Please email completed referral to: n2scontact@nhs.net

*Please use an nhs.net email address to ensure security (all practices should have one set up) and clearly state **PCO Referral** in the subject*