

Cataracts/Lens Extraction

BEFORE providing patient identifiable data on this form, please confirm that the patient (or in the case of a minor or vulnerable adult with the parent/legal guardian/carer) has given appropriate **EXPLICIT CONSENT** for sensitive and personal information on this form to be passed to the Funding Team/CCG/CSU for processing.

Consent given: Yes

Please ensure a secure NHSmail email account (nhs.net) is used to submit this form.

Patient First name		Patient Surname		Hospital	
NHS No.		Date of Birth		Consultant	
GP F-code		CCG		UBRN	
Hospital No.		Referrer			

Additional information

Please submit completed form to the following email address:

bbccg.mseccg-funding@nhs.net

A decision will be made and the form returned within **3 working days** where all relevant information is provided.

N.B: Please ensure forms are clear and legible. Illegible forms will be returned to sender.

Group Prior Approval

M&SECCGs commission surgery for cataracts/lens extraction where the patient:

- is willing to have eye surgery. The referring optometrist or GP must discuss this with the patient before referring. The Shared Decision Making leaflet - **Deciding what to do about cataracts** - must form the basis for this discussion.



deciding-what-to-do-about-cataracts.pdf

- AND** with best corrected visual acuity 6/12 or worse in the worst eye assessed by the clinician as being due to a rectifiable lenticular opacity.
- AND** where the reduced visual acuity significantly interferes with activities of daily living.

Please tick which boxes apply:

(Please complete separate forms for bilateral requests)

First Eye Prior Approval

Left

Right

Second Eye Prior Approval

Left

Right

Individual Prior Approval

Patients with best corrected visual acuity of better than 6/12 in the worst eye will not normally be offered surgery unless there is evidence of very significant impact on activities of daily living. A description of this impact must accompany the referral information (as detailed below), and including confirmation that the patient is willing to have eye surgery. The referring optometrist or GP should discuss this with the patient before referring. The Shared Decision Making leaflet - **Deciding what to do about cataracts** - will form the basis for this discussion. Individual prior approval will be required.

PLEASE COMPLETE THE CRITERIA BELOW:

All referrals must be accompanied by a completed proforma and provide the following information. Incomplete proformas will be returned to the referrer for completion and will delay the referral.

<ul style="list-style-type: none"> • Details of the optical prescription for affected eye 	
<ul style="list-style-type: none"> • Corrected distance visual acuity for affected eye 	
<ul style="list-style-type: none"> • Corrected near visual acuity for affected eye 	
<ul style="list-style-type: none"> • Co-existing other eye conditions, management and current status 	
<ul style="list-style-type: none"> • Other co-existing medical conditions affecting vision or the eyes; management and status e.g. <ul style="list-style-type: none"> ○ Diabetes ○ Glaucoma ○ Any other medical condition impacting on vision 	
<ul style="list-style-type: none"> • Confirmation that the patient is willing to have eye surgery 	
<ul style="list-style-type: none"> • Using the patient's own words, the reasons why the patient's vision and lifestyle 	



are adversely affected by the cataract, and the likely benefit from surgery must be included in the referral	
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Second eye:
 Patients will be offered second eye surgery provided they fulfil the referral criteria (see above).
 Second eye surgery should be deemed urgent when there is resultant symptomatic anisometropia i.e. a large refractive difference between the two eyes resulting in poor binocular vision (this should be clearly recorded in the patient's notes).

M&SECCGs do not commission cataract surgery/lens extraction solely for the purpose of correcting longstanding pre-existing myopia (short sighted or near sighted) or hypermetropia (long sighted).

CCG USE:	Invoice ref:	Prior Authorisation requested by:	
Is the procedure approved or declined?		Name of Clinician	
Please indicate:			
Name		Contact number	
Signature		Date	
Date			