WECS 1

GWASANAETH GOFAL LLYGAID CYMRU

GIG CYMRU NHS WALES

FFURFLEN GAIS ARCHWILIAD IECHYD LLYGAID CYMRU

Llenwch y ffurflen hon gan ddefnyddio inc du ac mewn priflythrennau

Llywodraeth Cymru
Welsh Government

Rhan 1. – Manylion a Datganiad y Claf

Mr / Mrs / Miss / Ms / Dr / Arall Gwryw/Benyw Dyddiad geni:_____

Cyfenw: _____ Enwau cyntaf: _____

Cyfeiriad:_____

_____ Cod post: _____ Rhif ffôn:_____

Enw'ch meddyg: _____ Cyfeiriad y feddygfa: _____

Mae datgan eich grŵp ethnig yn ein helpu i bennu'ch perygl o gael clefyd y llygaid. Dewiswch un adran a thiciwch y blwch sy'n disgrifio'ch cefndir ethnig orau:

Cymwys ar gyfer Band 1 perygl o gael clefyd llygaid oherwydd cefndir ethnig

Gwyn Cymreig/Seisnig/Albanaidd /Gwyddelig Gog. Iw./Prydeinig ☐ Gwyddelig ☐ Arall ☐

Asiaidd/Asiaidd Prydeinig Indiaidd ☐ Pacistanaidd ☐ Tsieineaidd ☐ Bangladeshaidd ☐ Asiaidd Arall ☐

Du/Affricanaidd/Caribïaidd/Du Prydeinig Affricanaidd ☐ Caribïaidd ☐ Du arall ☐

Cymysg/aml-ethnig Gwyn a Du Caribïaidd ☐ Gwyn a Du Affricanaidd ☐ Gwyn ac Asiaidd ☐ Cymysg/aml-ethnig arall ☐

Grŵp ethnig arall Arabaidd ☐ Arall ☐ Nodwch _____

Os daliaf wybodaeth yn ôl neu os rhoddaf wybodaeth anghywir neu gamarweiniol, rwy'n deall ac yn derbyn y gallwn gael fy erlyn a/neu y gallwn fod yn destun achos sifil. Rwy'n cadarnhau bod gennyf yr hawl i Wasanaeth Gofal Llygaid Cymru, ac rwy'n cydsynio bod gwybodaeth berthnasol yn cael ei datgelu er mwyn gwirio hynny; cynllunio a gweinyddu'r gwasanaeth; ac atal a chanfod twyll. Rwy'n cytuno i dalu cost y gwasanaeth os gwelir yn nes ymlaen nad oes gennyf yr hawl i'w gael.

Llofnod y claf/gwarcheidwad: _____ Dyddiad: _____

Enw a chyfeiriad y gwarcheidwad _____

Rhan 2. – Datganiad Optometrydd/Ymarferydd Meddygol Offthalmig: Rwy'n tystio i mi gynnal:

BAND 1: ARCHWILIAD IECHYD LLYGAID CYMRU (EHEW) Mae'r isod yn berthnasol i'r claf:

Problem llygaid aciwt ac rwyf wedi cynnig apwyntiad iddo o fewn 24 awr o'r cais ☐

Golwg mewn un llygad yn unig ☐ Nam ar y clyw ☐ RP ☐ Arall ☐

Wedi'i gyfeirio gan weithiwr iechyd proffesiynol arall (nodwch): Opthom ☐ Meddyg teulu ☐ Fferyllydd ☐ Offthalm ☐ Arall ☐

Perygl o gael clefyd llygaid oherwydd cefndir ethnig (gweler uchod) ☐

Angen archwiliadau i gydymffurio â phrotocolau/canllawiau cytunedig Llywodraeth Cymru

DRSSW ☐ monitro: amau OHT/glawcoma ☐ AMD sych ☐ Arall ☐

BAND 2: YMCHWILIADAU / ARCHWILIADAU PELLACH

Mireinio cyn llawdriniaeth cataract ☐ Trawsnewid wedi llawdriniaeth cataract ☐

Mireinio OHT/glawcoma ☐ Cycloplegia ar blentyn ☐ Arall ☐

BAND 3: ARCHWILIAD DILYNOL EHEW

Dilyniant o fand 1 blaenorol ☐ Wedi llawdriniaeth cataract ☐ Arall ☐

Byddaf yn cymryd y camau canlynol: Ticiwch bob un sy'n berthnasol.

Cyngor / Adolygiad rheolaidd		*Atgyfeirio at HES – Fel mater o drefn*		*Adroddiad i'r meddyg teulu (angenrheidiol o fewn 7 diwrnod ym mhob achos)*	
Dilyniant gyda Band 3		*Atgyfeirio at HES – Brys (os yw'n berthnasol)*		*Adroddiad i HES*	
Dilyniant arall		*Atgyfeirio at HES – Argyfwng*		*Adroddiad i DRSSW*	
Tynnu corffyn estron neu flewyn amrant		*Atgyfeirio at feddyg teulu am bresgripsiwn meddyginiaeth*		*Adroddiad i arall*	
Rhoi Rx		*Atgyfeirio at feddyg teulu am reswm arall*			
Rhoi taleb		*Atgyfeirio at LVSW*		*Atgyfeirio at weithiwr proffesiynol arall*	
Y cyffuriau a awgrymwyd/roddwyd –					
Triniaeth ar gyfer llygaid sych		*Chloramphenicol*		*Diferion gwrth-alergedd*	
Cyffur arall					

Ticiwch bob symptom sy'n berthnasol a phob canfyddiad/cyflwr sy'n berthnasol i'r rheswm dros yr archwiliad neu i ganlyniad yr archwiliad

Symptomau		***Canfyddiadau/cyflyrau***			
Dim un		*Dim annormaledd clinigol*		*AMD gwlyb*	
Problem golwg aciwt		*Llygaid sych/MGD*		*AMD sych*	
Problem gronig â'r golwg		*Amrant, blewyn amrant, lacrymaidd, crau llygaid*		*Macwlaidd – arall*	
Llygaid coch		*Corffyn estron/trawma arall*		*Toriad/datgysylltiad yn y retinâu*	
Fflachiau		*Cyfbilen*		*PVD neu wydrog arall*	
Brychau		*Cornbilen/sglera*		*Retinâu – arall*	
Poen/anesmwythder yn y llygaid		*Cataract / lens / IOL / PCD*		*Amau glawcoma/OHT*	
Pen tost/cur pen		*Iris/corffyn cilaraidd*		*Nerf optig / llwybr gweledol / meigryn*	
Diplopia		*Cyflyrau'r cyhyr llygadol/deulygad/cymhwysiad/plygiant – oedolion*			
Arall (rhowch fanylion isod)		*Cyflyrau'r cyhyr llygadol/deulygad/cymhwysiad/plygiant – plant*			
		Cymhlethdodau wedi llawdriniaeth/anhwylderau sydd heb eu dosbarthu rywle arall			

I'w lenwi gan yr optometrydd sydd wedi cynnal yr archwiliad hwn. Os rhoddaf wybodaeth sy'n anghywir neu'n anghyflawn, rwy'n deall y gellid dwyn achos yn fy erbyn. Rwy'n cydsynio bod gwybodaeth berthnasol yn cael ei datgelu er mwyn dilysu'r hawliad hwn, ac er mwyn atal a chanfod twyll.

Llofnod	Enw'r optometrydd a chyfeiriad y practis (priflythyren neu stamp):
Dyddiad: / /	
Rhif ar y rhestr offthalmig / atodol	

"Os cafodd yr archwiliad llygaid ei gynnal gan y contractiwr, dim ond un llofnod sydd ei angen ar waelod y ffurflen hon".

I'w lenwi gan gontractiwr neu gan lofnodwr awdurdodedig. Rwy'n hawlio'r ffi gyfredol ar gyfer y claf hwn o dan Wasanaeth Gofal Llygaid Cymru. Rwy'n datgan bod yr wybodaeth a roddwyd ar y ffurflen hon yn gywir ac yn gyflawn ac mai hon yw'r ffurflen wreiddiol a lofnodwyd gan y claf. Os daliaf wybodaeth yn ôl neu roi gwybodaeth anghywir neu gamarweiniol, rwy'n deall y gellid dod ag achos disgyblu yn fy erbyn ac y gallwn gael fy erlyn neu y gallwn fod yn destun achos sifil. Rwy'n cydsynio bod gwybodaeth berthnasol yn cael ei datgelu er mwyn gwirio'r hawliad hwn, ac er mwyn atal a chanfod twyll.

Llofnod	Enw a chyfeiriad y contractiwr (priflythyren neu stamp):
Dyddiad: / /	
Rhif ar y rhestr offthalmig:	Y cyfeiriad y dylid anfon y taliad iddo (os yw'n wahanol i gyfeiriad y contractiwr)

WECS 1

WALES EYE CARE SERVICE (WECS)

GIG CYMRU NHS WALES

EYE HEALTH EXAMINATION WALES APPLICATION FORM

Complete this form using black ink and in block capitals

Llywodraeth Cymru
Welsh Government

Part 1. – Patient's Details and Declaration

Mr / Mrs / Miss / Ms / Dr / Other Male / Female D.O.B:_____

Surname: _____ First Names:_____

Address:_____

_____ Postcode: _____ Tel Number: _____

Doctor's name: _____ Surgery Address: _____

Stating your ethnicity helps to determine your risk of eye disease. Please choose one section and tick the box that best describes your ethnic background:

Eligible for Band 1 at risk of eye disease due to ethnic background

White Welsh / English / Scottish / N Irish / British ☐ Irish ☐ Other ☐

Asian / Asian British Indian ☐ Pakistani ☐ Chinese ☐ Bangladeshi ☐ Other Asian ☐

Black / African / Caribbean / Black British African ☐ Caribbean ☐ Other Black ☐

Mixed / multiple White and Black Caribbean ☐ White and Black African ☐

White and Asian ☐ Other mixed / multiple ☐

Other ethnic group Arab ☐ Other ☐ State _____

I understand and accept that if I withhold information or provide false or misleading information I may be liable to prosecution and or civil proceedings. I confirm that I am entitled to this EHEW and I consent to the disclosure of relevant information for the purpose of checking this; planning and administering the service; and in relation to the prevention and detection of fraud. I agree to pay the cost of the service if I am later found not to be entitled to it.

Patient's / Guardian's signature: _____ Date: _____

Guardian's name and address:_____

Part 2. – Optometrist / OMP Declaration: I certify that I carried out a:

BAND 1: EYE HEALTH EXAMINATION WALES (EHEW) The patient:

Has an acute eye problem and I have offered them an appointment within 24hrs of request ☐
Is Uniocular ☐ Is hearing impaired ☐ Has RP ☐ Other ☐

Was referred by other healthcare professional, please indicate: Optom ☐ GP ☐ Pharmacist ☐
Ophthalmologist ☐ Other ☐

Is at risk of eye disease due to ethnic background (see above) ☐

Needs investigations to comply with WG agreed protocols / guidelines

DRSSW ☐ OHT / glaucoma suspect monitoring ☐ Dry AMD ☐ Other ☐

BAND 2: FURTHER INVESTIGATION / EXAMINATIONS

Cataract pre-op refinement ☐ Cataract Post-op conversion ☐ OHT / glaucoma refinement ☐
Cycloplegia on a child ☐ Other ☐

BAND 3: EHEW FOLLOW-UP EXAMINATION

Follow-up from previous band 1 ☐ Post-op cataract ☐ Other ☐

WECS1_062016_003 Wales Eye Care Services (WECS).indd 3 07/06/2017 14:54

I will take the following action: Please tick **all** that apply.

Advice / Regular routine review		*Referred HES-Routine*		*Report to GP (required in all cases* within 7 days*)*	
Follow-up with Band 3		*Referred HES-Urgent (if applicable)*		*Report to HES*	
Other Follow up		*Referred HES-Emergency*		*Report to DRSSW*	
Foreign body or eyelash removal		*Referred GP to prescribe medication*		*Report to other*	
Rx issued		*Referred to GP for other*			
Voucher issued		*Referred to LVSW*		*Referred to other professional*	
Drugs advised / supplied –					
Dry eye treatment		*Chloramphenicol*		*Anti-allergy drops*	
Other drug					

Please tick all symptoms that apply and all findings / conditions that are relevant to the reason for, or outcome of, the EHEW.

Symptoms		*Findings / conditions*			
None		*No clinical abnormality*		*Wet AMD*	
Acute vision problem		*Dry eye / MGD*		*Dry AMD*	
Chronic vision problem		*Eyelid, eyelash, lacrimal, orbit*		*Other macula*	
Red eye		*Foreign body / other trauma*		*Retinal break / detachment*	
Flashes		*Conjunctiva*		*PVD or other vitreous*	
Floaters		*Cornea / sclera*		*Other retinal*	
Eye pain / discomfort		*Cataract / lens* / IOL / PCO		*Suspect Glaucoma / OHT*	
Headaches		*Iris / ciliary body*		*Optic nerve / visual pathway / migraine*	
Diplopia					
Other (detailed below)		*Ocular muscle / binocular / accommodation / refraction conditions – adults*			
		Ocular muscle / binocular / accommodation / refraction conditions – children			
		Post op complications / disorders not classified elsewhere			

To be completed by the optometrist who has conducted this examination. I understand that if I give information that is incorrect or incomplete, action may be taken against me. I consent to the disclosure of relevant information for the purpose of verification of this claim and for the prevention and detection of fraud.

Signature	Optometrists name and practice address (Capitals or Stamp):
Date: / /	
Ophthalmic / Supplementary List number:	

"If the eye examination has been conducted by the contractor, only one signature is required at the bottom of this form".

To be completed by contractor or authorised signatory. I claim the current fee for this patient under the Wales Eye Care Service. I declare that the information given on this form is correct and complete and that this is the original form signed by the patient. I understand and accept that if I withhold information or provide false or misleading information, disciplinary action may be taken against me and I may be liable to prosecution and or civil proceedings. I consent to the disclosure of relevant information for the purpose of verification of this claim and in relation to the prevention and detection of fraud.

Signature	Contractor's name and address (Capitals or Stamp):
Date: / /	
Ophthalmic List number:	Address where payment should be sent: (if different from contractor address)