

To all GP Practices, General Practitioners and Practice Nurses

14 February 2007

Dear Health Professional

**New arrangements for referral to and exclusions from the Diabetic Eye Screening Programme of Lambeth, Southwark and Lewisham PCTs**

You may be aware that, from 31<sup>st</sup> December 2006, all Diabetic Retinopathy Screening should be by Digital Imaging in order to comply with National Service Framework for Diabetes and National Screening Committee (NSC) guidelines.

Lambeth, Southwark and Lewisham PCTs have commissioned Guys and St Thomas' NHS Foundation Trust (GSTT) to deliver the diabetic retinopathy screening programme. GSTT has provided this service through the Diabetes Eye Complications Screening (DECS) service for many years. The programme will meet the quality assurance criteria of the (NSC). These include:

- a programme which screens at least 12,000 people with diabetes annually;
- a digital photographic record of screening and other quality assurance criteria requirements.

Unfortunately, the present optometry-based screening service does not meet these stringent quality assurance criteria. This service will therefore be discontinued. **Existing patients in the optometry scheme will need to be referred by primary care clinicians to the DECS service.**

DECS is provided at four sites located within the Diabetes Centres at King's College, Guy's and St Thomas' Hospitals and University Hospital Lewisham. A further community site in Streatham will become operational in 2007. From January 2007, all referrals and correspondence should be made via the DECS Central Office at St. Thomas Hospital; this office will develop the call-recall register mentioned above.

## How to make a referral

Complete the attached "GP Practice Referral Form". Please ensure that you include as requested the demographic details, **the NHS number as the identifier for the database**, appropriate clinical information, the GP's name and address, and the DECS centre which will be most convenient for the patient to attend. Forward the completed form to DECS central office below.

## How to inform DECS about exclusions from the recall system

Complete the attached declaration for exclusion form, documenting clearly the reason for exclusion. Forward the completed form to DECS central office below.

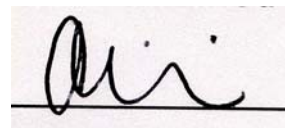
**DECS Central Office**  
**Block 6, 2<sup>nd</sup> Floor South Wing**  
**St. Thomas Hospital**  
**Lambeth Palace Road,**  
**London SE1 7EH.**

**Tel: 020 7188 1979**  
**Fax: 020 7188 9540**  
**E-mail [DECSenquiries@gstt.nhs.uk](mailto:DECSenquiries@gstt.nhs.uk).**

Yours sincerely



Dr Hiten Dodhia  
Consultant in Public Health  
Chair LSL Retinopathy Working Group



Dr Richard Wrigley  
Acting Medical Director  
Lambeth PCT

# DECS Diabetic Eye Complications Screening

## GP Practice Referral Form

- *THIS FORM IS FOR NEW REFERRALS. Screening is recommended for people with diabetes aged 12 years and over.*
- *To change follow-up / recall appointments, please contact the central DECS office by phone (020 7188 1979), fax (020 7188 9540) or email ([DECSenquiries@gstt.nhs.uk](mailto:DECSenquiries@gstt.nhs.uk)).*
- *PLEASE CIRCLE PREFERRED DECS SCREENING CENTRE:*

ST. THOMAS' HOSPITAL

GUY'S HOSPITAL

KING'S COLLEGE HOSPITAL

UNIVERSITY HOSPITAL LEWISHAM

- *ADVISE PATIENTS NOT TO DRIVE AS EYEDROPS WILL BE GIVEN. THEY SHOULD BRING SUNGLASSES IF POSSIBLE AND A LIST OF ALL PRESCRIPTION MEDICINES. PATIENTS SHOULD BRING THEIR CURRENT DISTANCE SPECTACLES (OR VARIFOCALS/BIFOCALS IF WORN) TO THE SCREENING APPOINTMENT*
- *NHS no and details of the referring clinician are essential.*

SURNAME \_\_\_\_\_ FORENAME \_\_\_\_\_ M / F

ADDRESS \_\_\_\_\_

D.O.B. \_\_\_\_\_ TELEPHONE \_\_\_\_\_ NHS NO \_\_\_\_\_

TREATMENT for Diabetes:

OTHER MEDICAL HISTORY

EYE HISTORY if known:

PREVIOUS RETINAL SCREENING HISTORY if known:

GP Name & Practice (*stamp or label preferred*):

SIGNATURE

DATE

- *PLEASE SEND THIS FORM TO:*

DECS Central Office  
Block 6, 2nd Floor South Wing  
St. Thomas Hospital  
Lambeth Palace Road  
London SE1 7EH

## Declaration for Exclusion from Diabetic Retinopathy Screening

SURNAME:..... FORENAME:..... M / F

ADDRESS:.....

D.O.B..... TELEPHONE:..... NHS No:.....

GP Name & Practice (*stamp or label preferred*):

### General Practitioner's Declaration

This patient should be suspended from Diabetic Retinopathy Screening for the following reason:

- This person is under the age of 12 years and screening will be deferred until after 12<sup>th</sup> birthday.
- This person has no perception of light in either eye (include report from Ophthalmologist).
- This person is currently under the care of an ophthalmologist for treatment and management of diabetic retinopathy (please include report from Ophthalmologist).
- This person is terminally ill.
- Screening and treatment for diabetic retinopathy is inappropriate for this person for the reason(s) below. Consider that healthcare providers must not discriminate against patients who are not able to access standard services (e.g. due to physical or mental impairment) and that advice should be sought for e.g. from a social worker and / or an ophthalmologist.

- I have explained the risks of Diabetic Eye Disease and the purpose of screening procedures to the above named patient; however she/he has requested temporary / permanent exclusion from the screening register (please ask patient to countersign declaration below).

GP's Signature

Date

### Patient's Declaration (circle as appropriate)

- I request temporary exclusion from Diabetic Retinopathy Screening for a period of .....months.

Or

- I hereby consent to permanent exclusion from Diabetic Retinopathy Screening

I confirm that I have understood the risks of Diabetic Eye Disease and the purpose of screening in the prevention of visual loss due to Diabetic Retinopathy. However I do not wish to attend for a screening examination.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_