|  |  |  |
| --- | --- | --- |
| **For completion by the Chief Executive/Medical Director of requesting healthcare organisation** | | |
| Name of organisation requesting review |  | |
| Subspecialties to be reviewed | Please select from the list below as relevant, more than one option can be chosen  Cataract  Medical retina  Vitreoretinal  Adnexal (lid, orbital, lacrimal)  Glaucoma  Paediatrics and or strabismus  Cornea/external disease  Refractive  Other (state what)  Whole service | |
| What has triggered the review?  Please select from the list as relevant, more than one option can be chosen | Concerns raised by staff  Serious incident(s)  Patient complaint(s)  Internal review  External review | Commissioner or regulator concern  Audits/outcome data  Recent changes to service delivery  Planned changes to service delivery |
| Other (please comment) | |
| What areas need review?  Please select from the list as relevant, more than one option can be chosen | Service delivery, productivity or efficiency  Workforce issues  Interpersonal behaviours  Multidisciplinary clinical team working  Clinical workload  Protocols and patient pathways | Clinical leadership  Trainees  Clinical governance/safety  Interaction with patients  Facilities and resources  Clinician/management relationship |
| Other (please comment) | |
| Comments / background / description of problems |  | |
| What steps have already been taken?  Please select from the list as relevant, more than one option can be chosen | Discussions with staff  Clinical record reviews  Internal audit  Internal investigation  External peer review  Pathway or protocol redesign | Restrictions on practice  Contact with GMC, CQC, NCAS |
| Give brief details especially on any other agencies involved |  | |
| Add any other information, or any specifics on what you are asking the College to do |  | |

|  |  |
| --- | --- |
| **Contact details for the Chief Executive/Medical Director:** | |
| Name |  |
| Post | Chief Executive  Medical Director  Other please specify: |
| Address |  |
| Telephone number |  |
| Email |  |
| Name and contact details of clinical lead for ophthalmology |  |

|  |  |
| --- | --- |
| **Fees: Please provide the name and contact details to which the invoice for the review should be sent along with a purchase order number for the review** | |
| Name |  |
| Role |  |
| Contact Details |  |
| Purchase Order Number for Invoice |  |

|  |  |
| --- | --- |
| **Declaration: I have read and agree to the review conditions set out in the College’s External Review Guidance Document (October 2017)** | |
| Name and designation (Chief Executive/ Medical Director) |  |
| Signed |  |
| Date |  |

Please send to: Professional Support Department, The Royal College of Ophthalmologists, 18 Stephenson Way, London, NW1 2HD

[beth.barnes@rcophth.ac.uk](mailto:beth.barnes@rcophth.ac.uk)