**Patient Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | NHS No. |  |
| Address |  | Date of Birth |  |
| Preferred Telephone Number |  |
| Other Telephone Number |  |
| Email |  | Dates Not Available |  |

**Referrer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Clinician |  | Date of Referral |  |
| GP / Optom Practice |  |  |  |
| Address |  | Telephone |  |
| Email |  |

**Patients Registered GP**

|  |  |  |  |
| --- | --- | --- | --- |
| Patients GP Practice |  | GP Address |  |

**Referral Timeframe**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | within 2 / 52  (Refer directly to secondary care) |  | Urgent – within 6 / 52 |  | Routine – within 18 / 52 |

**Is this a Re-referral?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | Date of original referral: |  |

**Reason for Referral**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Cataract (patient wants to be considered for surgery) |  | Oculoplastics / Orbital / Lacrimal |
|  | Cornea |  | Oncology |
|  | Diabetic Eye Disease |  | Orthoptics |
|  | External Eye Disease |  | Other Medical Retina |
|  | Glaucoma |  | Strabismus/Ocular Motility |
|  | Laser (YAG Capsulotomy) |  | Vitreoretinal |
|  | Low Vision |  | Paediatrics- Not Otherwise Specified |
|  | Neuro-ophthalmology |  | Paediatrics - Orthoptics |
|  | Not Otherwise Specified |  | Paediatrics – Strabismus/Ocular Motility |

**AC Angle; Tonometry; Disc Assessment; Visual Fields**

|  |  |  |
| --- | --- | --- |
| Date: Time: | **Right** | **Left** |
| AC Van Herick (Narrow : ≤1/4) |  |  |
| NCT/ icare / Tonopen |  |  |
| Goldmann/ Perkins |  |  |
| C:D ratio / Disc Size / ISNT |  |  |
| Disc Normal / Abnormal |  |  |
| VF Instrument / Strategy Used |  |  |
| VF Normal /Abnormal |  |  |

**Sight Test Details**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Vision** | **Sph** | **Cyl** | **Axis** | **VA** | **Prism H** | **Prism V** | **Add** | **Near VA** |
| **Right** |  |  |  |  |  |  |  |  |  |
| **Left** |  |  |  |  |  |  |  |  |  |
| **Previous VA >** | | Date |  | Right |  | Left |  |  |  |
| **Previous Near VA >** | | Date |  | Right |  | Left |  |  |  |

**Reason for Referral & Further Details: *inc. existing or previous patient of HES***

|  |  |
| --- | --- |
|  | |
| **Medical Problems:** | |
| **Allergies:** | |
| **Medication:** | Acutes       Repeats |