**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | NHS No. |  |
| Address |  | Date of Birth |  |
| Home Telephone |  |
| Work Telephone |  |
| Email |  | Mobile Telephone |  |

**Referrer Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Clinician |  | Date of Referral |  |
| GP/Optom Practice |  | Dates Not Available |  |
| Address |  | Telephone |  |
| Fax |  |

**Patients Registered GP:**

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

**Action Required**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Cancer – 2/52 (refer direct to secondary care, not via CCG) |  | Urgent – within 4/52 |  | Routine – within 18/52 |

**Is this a Re-referral?**

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

**Reason for Referral**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Cataract |  | Oculoplastics / Orbital / Lacrimal |
|  | Cornea / Conjunctiva |  | Orthoptics |
|  | External Eye Disease/ Anterior Eye |  | Paediatric ( Under 18 years ) |
|  | Glaucoma |  | PCO / IOL (Incl. YAG) |
|  | LVA Clinic |  | Squint / Ocular Motility |
|  | Neuro-Ophthalmology |  | Vitreo Retinal |
|  | Wet AMD |  | Medical Retina (Incl. DMR) |
|  |  |  | Non Specific Eye Condition |

**Tonometry & Disc Assessment**

|  |  |  |
| --- | --- | --- |
|  | **Right** | **Left** |
| Date/ Time |  |  |
| Disc Size |  |  |
| ISNT Rule Followed |  |  |
| Instrument |  |  |
| IOP Avg. |  |  |
| Local Pathway |  | |
| ESP Preference |  | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **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 |  |  |  |

**Further Details: *inc. existing or previous patient of HES***

|  |
| --- |
|  |

**Medical Problems:**

|  |
| --- |
|  |

**Allergies:**

|  |
| --- |
|  |

**Medication:**

|  |  |
| --- | --- |
| Acutes |  |
| Repeats |  |