**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 |       |