Ophthalmology Referral Form

ESSEXLOC LOCAL OPTICAL COMMITTEE

☐ **Please X box if for GP info only**

Reason for referral:-	**Cataract** ☐	**Glaucoma** ☐	**Macula** ☐	**Other *(please state):***
	Anterior ☐	**Vitro ret.** ☐	**Paediatric** ☐	**Examine for reassurance** (tick box if 2nd opinion required) ☐ **CVI** ☐

Priority:	**Emergency** *(Appt made via phone call toHES)* ☐	**Urgent – within 2 weeks** ☐	**Routine – within 18 weeks** ☐	**Indirect via GP** ☐

Patient details	
Surname	
First name	
Date of birth	
Telephone number	
Mobile number	
Address	
Postcode	
Doctor	
GP Surgery	
GP address	

Referring clinician's details	
Date	
Name	
GOC number	
Practice	
Address	

Tonometry				
	Reading 1		Reading 2	
	RE	LE	RE	LE
IOP Av. /mmHg				
Date				
Time				
Instrument				

Prescription details Date of sight test(if different):

	Vision	Sph	Cyl	Axis	Dist VA	Add	Near VA	Prism	PH
RE									
LE									

Other clinical details

	CD ratio	ONH	Other test results (*e.g. fields)*
RE			
LE			

Patient preferences

Hospital:

ESO:

Observations, ocular history, medication taken etc

The patient's consent to information being exchanged has been obtained ☐

Number of attachments 0