Association of Optometrists

# Remote consultation

Print and store securely after completion

## Part 1 To be completed by any staff member

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| **Patient name:** | **Patient reference:** |
| **Patient DOB (dd/mm/yy):** | **Date (dd/mm/yy):** |
| **Patient address:** | |
| | |
| **Patient telephone:** | |
| **Patient GP:** | **Referred by (if appropriate):** |

**Do you or any of your household have a high temperature, a new continuous cough or any symptoms of COVID-19?**

Yes No

**Is there anything worrying you about your vision?:**

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| **Red eyes?** Yes No Right Left Both | **Pain?** Yes No Right Left Both |
| **Has your vision suddenly become blurred?** Yes No Right Left Both | |

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| **Can you see OK to drive?** Yes No | **Can you read a number plate at 20m?** Yes No |
| **Can you see the television?** Yes No | **Can you see to read?** Yes No |

**Can you read on the computer?** Yes No

**If you use a computer how far away is it?** Arm's length Closer Further away

**Do you have any serious headaches?** Yes No **If so, how often?**

**Do you see two objects when there is only one?** Yes No

**If you see two of things, are they?** Above one another Side by side Both (diagonal)

**Are you seeing flashing lights in your vision, similar to a flash bulb going off in your vision?** Yes No

**Do you have floaters (black bits in your vision)?** Yes No

**Have they only just started?** Yes No

**How long have you had them?** Days Weeks Months Years

**Are there any shadows in your vision, similar to a curtain or a blind being pulled down?** Yes No

**Do you have any general health problems?** Yes No **If so, what?**

**Have you previously been told you have any of the following:**

**Cataracts/Early cataracts?** Yes No **Macular degeneration?** Yes No

**Wear and tear at the back of your eye?** Yes No **Glaucoma/raised pressure in your eyes?** Yes No

**Any other eye condition?** Yes No **If so, what was it?**

**Have any family members been told that they have an eye condition(s) that required hospital appointments?**
Yes No **If so, what was the condition?**

**Does the patient need to speak to an optometrist?** Yes No NA*
*If an optometrist completes Part 1, NA may be used

## Part 2 To be completed only by optometrist

**Additional history (if indicated):**

**Date of last sight test (dd/mm/yy):**

**Existing spectacle prescription (including VA if known)**

**Prescription taken from:** Previous prescription Focimetery

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**Additional information:**

**Arrange face-to-face appointment?** Yes No **If so, when? (dd/mm/yy):**

**Secondary care or higher qualification advice and guidance sought?** Yes No

**Name of person providing advice and guidance:**

**Advice given to optometrist:**

**Advice given to patient:**

**Information sent to patient?** Yes No **Patient referred onwards** Yes No

**Details:** **Destination:**

**Optometrist:** **GOC number:**