Ophthalmology Referral form

Reason for referral:	Cataract ☐	Glaucoma ☐	Macula ☐	Other *(please state)*
	Anterior ☐	Vitro ret. ☐	Paediatric ☐	

Priority:	Emergency ☐ *(Appt made via phone call to HES)*	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.				
Date				
Time				
Instrument				

Prescription details					Date of sight test:					Patient preferences
	Vision	Sph	Cyl	Axis	Dist VA	Add	Near VA	Prism	PH	
RE										Hospital:
LE										
Other clinical details										
	CD ratio	ONH	Other test results (*e.g. fields)*							ESO:
RE										
LE										

Observations, ocular history, medication taken etc

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