**Patient Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | NHS No. |       |
| Address |       | Date of Birth |       |
| Preferred Telephone Number |       |
| Other Telephone Number |       |
| Email |       | Dates Not Available |       |

**Referrer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Clinician |       | Date of Referral |       |
| GP / Optom Practice |       |  |  |
| Address |       | Telephone |       |
| Email |       |

**Patients Registered GP**

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

**Referral Timeframe**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | within 2 / 52 (Refer directly to secondary care)  | [ ]  | Urgent – within 6 / 52 | [ ]  | Routine – within 18 / 52 |

**Is this a Re-referral?**

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

**Reason for Referral**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | Cataract (patient wants to be considered for surgery) | [ ]  | Oculoplastics / Orbital / Lacrimal |
| [ ]  | Cornea  | [ ]  | Oncology |
| [ ]  | Diabetic Eye Disease | [ ]  | Orthoptics |
| [ ]  | External Eye Disease | [ ]  | Other Medical Retina |
| [ ]  | Glaucoma | [ ]  | Strabismus/Ocular Motility |
| [ ]  | Laser (YAG Capsulotomy) | [ ]  | Vitreoretinal |
| [ ]  | Low Vision | [ ]  | Paediatrics- Not Otherwise Specified |
| [ ]  | Neuro-ophthalmology | [ ]  | Paediatrics - Orthoptics |
| [ ]  | Not Otherwise Specified  | [ ]  | Paediatrics – Strabismus/Ocular Motility  |

**AC Angle; Tonometry; Disc Assessment; Visual Fields**

|  |  |  |
| --- | --- | --- |
| Date: Time: | **Right** | **Left** |
| AC Van Herick (Narrow : ≤1/4) |       |       |
| NCT/ icare / Tonopen  |       |       |
| Goldmann/ Perkins  |       |       |
| C:D ratio / Disc Size / ISNT  |       |       |
| Disc Normal / Abnormal |       |       |
| VF Instrument / Strategy Used |       |       |
| VF Normal /Abnormal |       |       |

**Sight Test Details**

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

**Reason for Referral & Further Details: *inc. existing or previous patient of HES***

|  |
| --- |
|       |
| **Medical Problems:**       |
| **Allergies:**        |
| **Medication:**  | Acutes       Repeats       |