Ophthalmology Referral

Fax to 0333 240 7729

Or NHS mail to LCHevolutio@nhs.net

Only 1 patient per fax transmission

Patient Details	
Surname	
First Name	
Date of Birth	
NHS No.	
Tel. No.	
Mobile No.	
Address	
Postcode	
Dr	
GP Surgery	
GP Address	

Referring Clinician Details	
Name	
GOC No.	
Practice	
Address	
Referral Date	

Action Required	
	Cancer – 2/52
	Urgent – within 2/52
	Routine – within 18/52

Referral Reasons	
	Anterior Eye
	Cataract
	Cornea / Conjunctiva
	External Eye Disease
	Glaucoma
	LVA Clinic
	Neuro-Ophthalmology
	Non Specific Eye Condition
	Oculoplastics / Orbital / Lacrimal
	Orthoptics
	Paediatric (Under 18 months)
	PCO / IOL (Incl. YAG)
	Squint / Ocular Motility
	Vitreo Retinal
	Medical Retina (Incl. DMR)

Tonometry & Disc Assessment	Right	Left
Date / Time		
Disc Size		
ISNT Rule Followed		
Instrument		
IOP Avg.		

Local Pathway	
ESP Preference	
HES Preference	

	Vision	Sph	Cyl	Axis	VA	Add	Prism	Base
Right								
Left								

Previous VA ➔	Date		Right		Left		

Observations: evolutio to send referral to appropriate provider. Info only for GP unless stated above.

The patient's consent to information being exchanged has been obtained via the consent form ☐ Attachments Enclosed ☐

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