Please send this form to BUS via EeRS/ EyeV platform

Milton Keynes Hospital NHS
NHS Foundation Trust

REFERRAL FORM
TO THE BOOKED URGENT SERVICE – EYE DEPARTMENT

PLEASE PRINT CLEARLY IN BLACK INK (No rubber stamps please)

NHS No. / Hospital No. and Patient's name:

DOB: / /

Patient's phone no. home / mobile:

Practice address of referring GP/optometrist

Please include details of next of kin where applicable.

- **Only refer patients who are not eligible to be seen under CUES (see separate flowchart).**
- **Suspect wet AMD cases should ideally be referred on the wet AMD rapid access referral form.**
- **The eye department will phone the patient to make an appointment within 3 working days.**
- **The patient is the referrer's responsibility until an appointment is allocated.**

Provisional Diagnosis –

Best corrected visual acuity: - R / L /

Symptoms, signs, duration, treatment previous ocular history and medical history:

Name of referrer –
GOC/GMC No. –
Practice phone No.–

Signed –
Date –

Ophthalmologist:	Date:	Action:

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BUS proforma Version 5

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