**Emergency Eye Clinic (EEC)**

**Service Details**

Emergency eye clinics are run daily as a booked clinic. Clinic slots are available between the hours of 09.00 – 17.30 Monday to Friday, and Saturday 09.00 - 13.00. Patients need to be referred by their GP or optometrist using the e-referral form below: **it is not a walk-in service.**

Urgent referrals to this clinic are processed daily by the triage nurse on duty with doctor input when needed. Once triaged, patients will be contacted and booked into an appropriate slot based on clinical urgency and availability.

For eye emergencies during or outside of these hours when the referrers opinion is that the patient needs to be seen immediately, the on call triage nurse/ doctor is available via the switch board for advice. The Emergency Department is also available 24 hours a day for all medical emergencies. **Patients should only present to the Emergency Department if the symptoms or diagnosis is sight or life threatening.**

**----------------------------------------------------------------------------------------------------------------**

**Royal Cornwall Hospital Trust**

**The Eye Unit, Ground Floor, Tower Block, Treliske Hospital, Truro, TR1 3LJ**

**Email** rch-tr.EmergencyEyeClinic@nhs.net

**Treliske Switchboard 01872 250000**

**----------------------------------------------------------------------------------------------------------------**

See next page for referral form

**Emergency Eye Clinic (EEC)**

**Referral Form**

To be Completed by Community Optometrist / GP

Please note all fields are mandatory and should be completed electronically. Incomplete forms will be returned and may result in delays.

**Please ensure EEC Referral is appropriate, see** [**here**](http://rms.kernowccg.nhs.uk/primary_care_clinical_referral_criteria/opthamology) **for guidance**

(http://rms.kernowccg.nhs.uk/primary\_care\_clinical\_referral\_criteria/ophthalmology)

|  |
| --- |
| **Patient Details** |
| Name: Click here to enter text. | Date of birth: Click here to enter text. |
| Address: Click here to enter text. | Phone number: Click here to enter text. |
| Post code: Click here to enter text. | NHS (if known): Click here to enter text. |
| **GP and Optometrist Details** |
| GP Name: Click here to enter text. | Surgery address: Click here to enter text. |
| Optometrist Name: Click here to enter text. | Practice address: Click here to enter text. |
| **Referrer Details** |
| Referrer Name: Click here to enter text. | Referrer contact: Click here to enter text. |
| Date of Referral: Click here to enter text. | Time of Referral: Click here to enter text. |

**Please indicate if any of the following apply**

|  |  |  |  |
| --- | --- | --- | --- |
| Hard of hearing | [ ]  | Partially sighted | [ ]  |
| Learning disability | [ ]  | Communication difficulty | [ ]  |
| Sign language | [ ]  | Aphasia | [ ]  |
| Interpreter requiredIf yes, please state language: | [ ]  | Advocacy services needed | [ ]  |

**History of Presenting Complaint**

|  |
| --- |
| Click here to enter text. |

**Ocular History**

|  |
| --- |
| Please include prior surgery and other eye history:Click here to enter text. |

**Medical History**

|  |
| --- |
| Please insert text or attach a patient profile (patient to bring a list of medications):Click here to enter text. |

**Symptoms**

|  |  |  |
| --- | --- | --- |
| Right [ ]  | Left [ ]  | Both [ ]  |
| How long has the patient had symptoms for? |
| For Click here to enter text. days **OR** Click here to enter text. months |
| Pain score (0 = none, 10 = worst imaginable) |
| 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | 4[ ]  | 5[ ]  | 6[ ]  | 7[ ]  | 8[ ]  | 9[ ]  | 10[ ]  |
| Photophobia | None [ ]  | Mild [ ]  | Moderate [ ]  | Severe [ ]  |
| Redness | None [ ]  | Mild [ ]  | Moderate [ ]  | Severe [ ]  |
| Loss of vision | None [ ]  | Blurred [ ]  | Partial [ ]  | Total [ ]  |
| Visual Acuity unaided(if no glasses) | R: Click here to enter text. | L: Click here to enter text. |
| Visual Acuity with glasses | R: Click here to enter text. | L: Click here to enter text. |
| Visual Acuity with pinhole | R: Click here to enter text. | L: Click here to enter text. |
| Gross fields intact? | Y [ ]  | N [ ]  | Specify Defect Click here to enter text. |
| Contact lens wearer | Y[ ]  | N [ ]  |  |
| Double vision | Y [ ]  | N [ ]  | Monocular or Binocular (disappears when one eye closes) delete as appropriate |
| Flashers, Floaters, Dark veil | None [ ]  | Sudden [ ]  | Recent [ ]  | Old [ ]  |
| Discharge | None [ ]  | Watery [ ]  | Purulent [ ]  |
| Trauma | None [ ]  | Mechanical [ ]  | Chemical [ ]  |

|  |  |  |
| --- | --- | --- |
| Symptoms of Giant Cell arteritis? (If no visual symptoms referral is via Rheumatology) | Y [ ]  | N [ ]  |
| FBC ESR CRP bloods taken?  | Y [ ]  | N [ ]  |

**Referrer – Please now send this referral to** rch-tr.EmergencyEyeClinic@nhs.net **If you are not referring from a GP surgery please send a copy of this form to the patient’s GP for their information. Thank you.**