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 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 required If 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.