

GOLDMANN APPLANATION TONOMETRY REFERRAL REFINEMENT AND PATIENT RECORD CARD



Kernow Clinical Commissioning Group

Intra Community Practice referral form and referral to Hospital Eye Service (if applicable).
Please complete only for patients with IOP 24mmHg or above, but no other signs of glaucoma.

In cases where other signs of glaucoma are present, the patient should be referred without refinement.

Patient Name.	D.O.B	Address	Tel. number

GP name	GP address

Originating Practice and Optometrist details.

Optometrist name	Optometrist practice name and address

Pre GAT information (to be completed by originating optometrist)

Date of Patient visit:

Please confirm that the patient has no other clinical signs of glaucoma and is being referred under the terms of the refinement service, please sign:

RX Near add	R	L
VA	R	L
AC/Van Herick (If done)	R	L
Mean of four Non-contact tonometry results	R	L
Optic disc	R	L

Visual field	R	L
If patient being referred to hospital	Field plot enclosed	YES / NO

'Referred to' practice details

Name	Address

Accredited Practitioner:
Please complete the follow and return to originating Optometrist or send copy of Pharmoutcomes records.

Post GAT assessment information

Assessment	Right Eye	Left Eye
IOP (GAT)		mmHg
Optic Disc		
Visual Field		
AC/Van Herick		
If patient referred to HES	Field plot enclosed	Yes/No

<p>Signature of Accredited Practitioner:</p> <p>Printed name of Accredited Practitioner:</p> <p>Date Performed:</p>

Outcome (Tick relevant box)

ACTION TAKEN	
<p>IOP 24 - 30 mmHg confirmed in one or both eyes – refer. Originating performer advised to refer to HES via patients GP.</p> <p>Return this form to that optometrist. (Accredited optometrist to keep a copy.)</p>	<p>General Clinical Commissioning Group</p>
<p>Results within normal limits in both eyes – discharge.</p> <p>Originating performer informed by returning this form. (Accredited optometrist to keep a copy.)</p>	
<p>IOP >3mmHg in one or both eyes – refer urgently to HES.</p> <p>GAT Optometrist to refer direct to Emergency Eye Clinic by email rch-tr.EmergencyEyeClinic@nhs.net.</p>	

Patient

I confirm that I have received the IOP Referral Refinement Local Enhanced Service.

The service has been fully explained to me and I have been given the appropriate explanatory leaflet.

Printed name of patient:

Signature of patient: _____ Date: _____