**UHCW NHS Trust Acute Eye Clinic Referral Form**

**Date: Date of exam:**

|  |  |
| --- | --- |
| **Patient Details** | |
| Name: Click here to enter text. | Date of birth: Click here to enter text. |
| Address: Click here to enter text. | Preferred Contact number (please list as many as possible): Click here to enter text. |
| **Referrer: GP Optician  A&E Dept** | |
| Referrer Name: | Referrer contact: |

**Presenting Complaint and Proposed diagnosis**

|  |  |  |
| --- | --- | --- |
| **Treated previously under MECS for same issue (Optom only)** | **Y** | **N** |
| **Does the patient have any of the following:**  • Fever  • New or Persistent Cough   Flu like symptoms    Have you had contact with anyone recently diagnosed with COVID-19?   Presenting Complaint: | | |

**Previous Ophthalmic History**

|  |
| --- |
| Please include prior surgery and other eye history: |

**Relevant Medical History**

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

|  |  |  |
| --- | --- | --- |
| Best Corrected Visual Acuity  unaided  pinhole glasses | R: | L: Click here to enter text. |
| Any Other Comments or Findings of Concern:  Click here to enter text. | | |

***Internal Use - Emergency Eye Clinic Referral Form Outcome Form***

**Action to be taken:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | See today | | |
|  | See within 1 day | | |
|  | See within 3 days | | |
|  | See in out-patient clinic (please specify)……… | | |
|  | Advise patient to see MECS scheme | | |
| |  |  | | --- | --- | |  | Book into Acute VR today | | | | |
| Appointment Booked | | Yes | No |
| Patient contacted | | Yes | No |

Triager: Date:

Obs required on arrival (please delete as required):

Visions

Dilate

Blood pressure

IOP

RAPD

Colour Vision

Other (please specify) …..