**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) …..