NHS Derbyshire CCG GOS Referral form Date

GP to arrange hospital appointment as patient wishes to choose an alternative process for referral

FAO Hospital / GP _____

Px Number

Clinic Specialising in Other

Refer as Routine

Patient **Female** Surname Forename

Address

Post Code D.O.B. Tel

Refraction Cycloplegic Refraction ☐ Dilated Examination ☐

	Vision	Sph	Cyl	Axis	Prism	Base	VA	PH	Add	N.VA	Prev VA
RE											
LE											

IOP **RE** **LE** @ with

Visual Fields **RE** Not Assessed **LE** Not Assessed N/A Copies Enclosed ☐

Provisional Diagnosis

GP Name & Address

Optometrist Name **OPL No**
Address & Tel

Optometrist's Signature

Optometrist Declaration: I confirm I have examined the above patient's eyes and that he/she consents to the exchange of information relating to their eye examination between the Optometrist, CCG, General Practioner and Hospital Consultants. I confirm I have offered "Choice"