Joined Up Care Derbyshire

For GP information only – no action required by GP ☐

NHS Derby & Derbyshire ICB GOS Referral form **Date**

Please Select from Options

FAO Hospital / GP / Triage Service Please Select from Options **Px Number**

Clinic Specialising in Please Select from Options **Refer as** Please Select from Options

Patient Please Select from Options **Last Name** **First Name**

Address

Post Code **D.O.B.** **Tel**

Email **Housebound** ☐ **Interpreter needed** ☐

Other reasonable adjustments Main Language Spoken

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** **LE** **Copies Enclosed** ☐

Provisional Diagnosis

Patient choice of optom if a MECS referral is required

GP Name & Address

Optometrist Name
Address & Tel

Optometrist's Signature **OPL No**

Please copy the referring optometrist/practitioner into any reply to the patient's GP so that the optometric referrer can appropriately manage this patient in the future.

Optometrist Declaration: I confirm I have examined the above patient's eyes and that they consent to the exchange of information relating to their eye examination between the Optometrist, ICB, General Practitioner and Hospital Consultants. I confirm I have offered "Choice".