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| **GOS18 Routine Ophthalmic Referral/Information for GP** | | | | | | | | | | | | | | | | | | | | | | | | | | | **Please use black ink to fill in this form** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of sight test** | | | | | | | | |  | | | | | | | | | | | | | | | | | | **Date of referral (if different)** | | | | | | | | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |
| **Optometrist/OMP Name and Practice Address** | | | | | | | | | | | | | | | | | | | | | | | | | | | **Patient details** | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | Title | | | | |  | | | | | | | | | | Gender | | | | | M / F | | | | |
| Surname | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Post Code:** | | | | | | |  | | | | | **Tel:** | |  | | | | | | | | | | | |  | Forenames | | | | |  | | | | | | | | | | | | | | | | | | | |
| **NHS mail:** | | | | | |  | | | | | | | | | | | | | | | | | | | |  | Address | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **GP Name and Practice Address** | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | Post Code | | | | | | | | |  | | | | |  |
| Telephone: | | | | |  | | | | | | | | | | | | | | | | | | |  |
| Date of Birth | | | | | |  | | | | | | | | | | | | | | | | | |  |
| NHS number (if known) | | | | | | | | | | | |  | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | |
| **GP Action Required:** (Also see “additional information below) | | | | | | | | | | | | | | | | | |  |  | | **ADULT CLINIC TYPE suggested, tick most urgent one** | | | | | | | | | | | | | | | | | | | **CLINICAL TERMS(S):** Enter relevant keyword(s) (these enable the GP to find correct HES service) | | | | | | | | | | | |
|  |  | |  | | | | | | | | | | | | | | |  |  | |  | | | | | | | | | | | | | | | | | | |
|  |  | |  | This letter is for INFORMATION ONLY | | | | | | | | | | | | | |  |  | |  | Cataract | | | | | | | | | | | | | | | | | |
|  |  | |  |  | |
|  |  | | Patient asked to telephone/visit GP | | | | | | | | | | | | | |  |  | | Cornea | | | | | | | | | | | | | | | | | |
|  |  | |  |  | |
|  |  | | Patient sent to Eye Casualty | | | | | | | | | | | | | |  |  | | Diabetic Medical Retina | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | |  |
|  |  | |  |  | |
|  |  | | Advise Referral to Eye Dept (URGENT) | | | | | | | | | | | | | |  |  | | External Eye Disease | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | |  |
|  |  | |  |  | |
|  |  | | Advise Referral to Eye Dept(Routine) | | | | | | | | | | | | | |  |  | | Glaucoma | | | | | | | | | | | | | | | | | |  |  |
|  |  | |  |  | |
|  |  | |  | | | | | | | | | | | | | | |  |  | | Laser (YAG capsulotomy) | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | |  |
|  |  | |  |  | |
| **CHILDREN (15 or under) CLINIC TYPE suggested, tick most urgent one** | | | | | | | | | | | | | | | | | |  |  | | Low Vision | | | | | | | | | | | | | | | | | |  |  |
|  |  | |
|  |  | | Oculoplastics/ Orbits / Lacrimal | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | |  |
|  |  | |
|  |  | | Other Medial Retina (incl ARMD) | | | | | | | | | | | | | | | | | |  |  |
|  |  | |
|  |  |  | | Strabismus and Amblyopia | | | | | | | | | | | | | |  |  | | Squint / Ocular Motility | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | |  |
|  |  |  |  | |
|  |  | Paediatric non-strabismus | | | | | | | | | | | | | |  |  | | Vitreoretinal | | | | | | | | | | | | | | | | | |  |  |
|  |  |  |  | |
|  |  | Orthoptic (only) | | | | | | | | | | | | | |  |  | | Not Otherwise Specified | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | |  |
|  |  |  |  | |  |  | | | | | | | | |  | |
|  |  |  | | | | | | | | | | | | | | | |  |  | |  | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | |  | |
|  | | | | | Sph | | | Cyl | | | Axis | | | | Prism | | Base | | | | | | VA | | Pinhole | | | Add | | | | | | Near Vision | | | | | Previous corrected VA on | | | | | | | | | | | | |
| (date) | | | | | |  | | | | | | |
| **Right** | | | | |  | | |  | | |  | | | |  | |  | | | | | |  | |  | | |  | | | | | |  | | | | |  | | | | | | | | | | | | |
| **Left** | | | | |  | | |  | | |  | | | |  | |  | | | | | |  | |  | | |  | | | | | |  | | | | |  | | | | | | | | | | | | |
|  | | | | |  | | |  | | |  | | | |  | |  | | | | | |  | |  | | |  | | | | | |  | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | **Right eye** | | | | | | | | | | | **Left eye** | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Visual fields | | | | | | | | | | | | | Normal/enclosed (if abnormal) | | | | | | | | | | | Normal/enclosed (if abnormal) | | | | | | | | | | | | | |
| Optic Nerve heads | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | C:D | | | | | | | | | | | C:D | | | | | | | | | | | | | |
| Intraocular pressure | | | | | | | | | | | | |  | | | | | | | mm Hg | | | |  | | | | | | | | mm Hg | | | | | | Applanation/non contact/ | | | | | | | | | | | | | |
| Time: | | | | |  | | | | | | | | Other | | | | | |  | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | | | |  | |  |
| Additional Information | | | | | | | | | | Cycloglegic refraction | | | | | | | | | | | | | | | | | | | | |  | | Dilated fundus examination | | | | | | | | | | | | | | | |  | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **GOS 18 Part One – This must accompany and referral made to an Eye Department** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **STATEMENT:** The reason for this referral has been explained to the patient or guardian who agrees to it. The patient or guardian also consented to information being exchanged between the Hospital Eye Service, Their General Medical Practitioner, and optometrist or ophthalmic medical practitioner (delete any not consented to). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | |
| If appropriate, Guardian’s name and address | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signed (optometrist/OMP) | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | GOC/GMC No | | | | | | |  | | | | | | | | | | | | | | | |

**GOS18 Routine Ophthalmic Referral/Information for GP (REAR)**

**Optometrist Guidance**

Most referrals to the HES are via ‶Choose and Book″ (CaB). This system provides two ways for a GP surgery to find an appointment in the correct service (e.g. clinic). Please note that the person doing this booking may not be a doctor.

1. **Priority is to complete ‶Clinic Type″ - Tick just one – the most urgent –**

**N.B Ensure you complete the correct Adult or Child section. Adults are 16 or over.**

* These Clinic Types are fixed and are the same throughout England.
* When a Clinic Type is entered on CaB all the services linked to it are displayed. For a simple one (such as Cataract) this will show all the clinics seeing cataracts and nothing else.
* Other Clinic Types may result in a range of different clinics being offered. However these clinics may only see a subset of the conditions covered by the Clinic Type. For instance Oculoplastic / Orbit / Lacrimal may link to a nurse led cyst service, a lid malposition (entropion etc) service or a service exclusively for lacrimal problems.

If a range of different types of clinic are offered the GP surgery will need to select the correct one. They can do so on the basis of the ‶Clinic Terms″ you have entered (see below) and/or the additional information you put on the free text part of the form.

**2. Then Complete “Clinical Term” – enter as many as is appropriate**

Enter as many clinical terms (such as ‶Entropion″) in the search field. In CaB this will show all the services which see patients with this problem or diagnosis.

This is particularly useful for conditions that the GP may not recognise, such as ‶Keratoconus″ or ‶Macular Dystrophy″

**You must provide both a Clinic Type and Clinical Term for all patients.**

**For Urgent or Emergency Referrals Please use the Emergency / Urgent Referral Form**