Retinal Vein Occlusion (RVO) Rapid Access Referral Form

Referral Eye Department:

Fax Number: **Email:**

Patient Details

Name:

DOB:

Address:

Contact Tel No's:

Optometrist details:

Name:

Practice (address): GOC NO:

Tel: Fax:

Affected Eye	**Right**	**Left**
Visual loss	☐ Yes ☐ No	☐ Yes ☐ No
Duration of visual loss:	(months)	(months)
Best Corrected Visual Acuity:		
Past ocular history (if relevant):		

Clinical signs - affected eye

1. Retinal venous tortuosity	☐ Yes ☐ No	☐ Yes ☐ No
2. Retinal haemorrhage	☐ Yes ☐ No no. of quadrants:	☐ Yes ☐ No no. of quadrants:
3. Disc swelling	☐ Yes ☐ No	☐ Yes ☐ No
4. Macular oedema	☐ Yes ☐ No	☐ Yes ☐ No

Diagnoses	**Right**	**Left**
Type of RVO	CRVO ▼ CRVO/HemiCRVO/BRVO	CRVO ▼ CRVO/HemiCRVO/BRVO
Other ocular abnormality:		

Patient's GP details:

GP Name: GP Surgery:

Contact details:

UK/0268/2012a Date of preparation: July 2013