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| **Patients Name:****Address:****Tel No: Home:**  **Mobile:**  **Work:****NHS No:** **DOB:** | **GP:****Surgery Address:****Tel No:****Fax:****Email:****Date of Referral:** |

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| **Does your patient require translation? If Yes, please state which language** |
| **Patients Ethnic Origin?**\*White Mixed Asian or Asian British Black or Black British Other   |
| **Please state any significant disability or personal safety issues** |
| **GSO18 Form Enclosed – please tick** **Patient consents to direct referral – please tick**  |
| **Reason for Referral – please tick below** New Glaucoma/raised Intra Ocular Pressure Dry Eyes BlepharitisFloaters or photopsia duration of 5 days or moreCataracts Other please detail below Please advise of any relevant allergies**Any other information or significant active problems** |
| **Post to: Solent Medical Services Ltd, Newtown Clinic, 24-26 Lyon Street, Southampton SO14 0LX****Ophthalmology Email :** **soccg.smsophthalmologyclinic@nhs.net****General Email :** **solent.medical-information@nhs.net****Alternatively: Referrals can be made via E-referral service (EBRS)** |

\*Ethnicity terminology taken from ONS2011 Census questionnaire for England