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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  Blepharitis  Floaters or photopsia duration of 5 days or more  Cataracts  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**](mailto:soccg.smsophthalmologyclinic@nhs.net)  **General Email :** [**solent.medical-information@nhs.net**](mailto:solent.medical-information@nhs.net)  **Alternatively: Referrals can be made via E-referral service (EBRS)** |

\*Ethnicity terminology taken from ONS2011 Census questionnaire for England