GPSI Referral form: Ophthalmology

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

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

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