East and North Hertfordshire NHS Trust

**URGENT EYE CLINIC REFERRAL FORM**

| Patient Details | Referrer Details |
|---|---|
| **First Name:** | **Name:** |
| **Surname:** | **Role** |
| **DOB:** | **Department/Ward:** |
| **Address:** | **Address:** |
| **Postcode:** | **Postcode:** |
| **Contact No:** | **Contact No:** |
| **Email** | **Email:** |

| | | |
|---|---|---|
| **Is the patient an:** | ☐**Inpatient** | ☐**Outpatient** |

| | | | |
|---|---|---|---|
| **Presenting Complaint:** | | | |
| **Duration of Symptoms:** | ☐**24-48 hours** | ☐**1 Week** | ☐**2 Weeks** |

| | | |
|---|---|---|
| **Visual Acuity:** Best corrected vision should be tested in ALL patients if possible | **Right Eye** | **Left Eye** |
| **Clinical findings and other relevant history: (please include IOP readings if available)** | | |
| **Details of PHOTO / VISUAL FIELDS / SCANS: (please attach to referral if available)** | | |
| | | |

**Save the form as a PDF and email to enh-tr.urgenteyereferral@nhs.net**

- Please ensure that all fields are completed, incomplete forms will be rejected and returned to sender
- This email is manned Monday – Friday 9am – 7pm and Saturday 9am – 12pm
- We do not provide an urgent eye service outside of these hours

We will triage and contact the patient directly with an appointment or advise on alternative services

**Walk-in patients will be re-directed back to the referrer**

**ABRIDGED REFERRAL GUIDE:**

1. This clinic is for adults and children that you feel have a **sight/life-threatening ophthalmological condition that requires hospital eye care within two weeks**
   - Including but not exclusive: penetrating/severe blunt trauma, chemical injury, sudden loss of vision, acute severe pain, acute angle closure, sudden onset diplopia, acute post-op complications
   - **Routine referrals must not be sent via this pathway**

2. If you are unsure whether your patient fits the urgent criteria, please complete this form - it will be triaged according to clinical need