**To:** ……………………………………………………………………………………… (GP, community eye clinic, hospital clinic, etc)

**This patient requires a specialist glaucoma assessment as their eye pressure is raised >24mmHg as per the REPEAT IOP (GAT) / REFERRAL REFINEMENT SCHEME PROTOCOL**

**To GP: Please refer patient as above/ Copy only – no action needed** (optom to delete as appropriate)

|  |  |  |
| --- | --- | --- |
| Patient’s Details |  | Optometrist / Practice |
| First name: |  |  | Optometrist: |  |
| Last name: |  |  | OPL number: |  |
| DOB: |  |  | Practice: |  |
| NHS number: |  |  |  |  |
| Address: |  |  |  |  |
|  |  |  | **Patient’s GP** |
|  |  |  | *GP name:* | .. |
| Phone: |  |  | Practice: |  |
| Mobile: |  |  |  |  |
| Email: |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Sight test­ details** | Vision | Sph | Cyl | Axis | Prism | VA | Add | Near VA |
| R |  |  |  |  |  |  |  |  |
| L |  |  |  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Tonometry Record** | **Date** | **Instrument** | **RE (mmHg)** | **LE (mmHg)** |
| *First Reading* |  |  |  |  |
| *First Applanation Reading* |  |  |  |  |
| *Repeat Applanation* |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Clinical findings** | **RE** | **LE** |
| *Optic nerve head appearance* |  |  |
| *Visual fields* |  |  |
| **Other relevant information** *(e.g. ophthalmic history, narrow angles, general health, family history of glaucoma)* |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Optometrist’s Signature: |  | Date: |  |

**STATEMENT:** The reason for this referral has been explained to the patient or guardian who agrees to it.
The patient or guardian also consents to information being exchanged between the Hospital Eye Service, their General Medical Practitioner, and optometrist or ophthalmic medical practitioner **(delete any not consented to)**.

Referral form to be sent direct to ophthalmology provider or via GP (Copies to GP, patient and practice records)