University Hospitals of Leicester

NHS Trust

**PATIENT DETAILS:**

Name:

Date of birth:

Address (including postcode):

Female

Male

Telephone: Home: Mobile:

|  |  |
| --- | --- |
|  **REFERRING OPTOMETRIST**  | **GP DETAILS** |
| Name:  | Name: |
| Practice Details:  | Practice Details: |
| Address:  | Address: |
| Telephone:  | Telephone: |

**AFFECTED EYE:** Right: Left: **REFERRAL:** **Emergency Urgent**

|  |
| --- |
| **Eye Casualty Referral Form** |

**PRESENTING COMPLAINT:**

|  |  |
| --- | --- |
| **PRESENTING SIGNS & SYMPTOMS IN AFFECTED EYE** *(please tick the relevant box)* **NB: Non-urgent cases will not be seen in the Eye casualty and may be referred back.** |  |
| Recent onset (< 1 week) Yes No  | Diplopia  | Yes No  |
| Painful, red eye Yes No  | Severe headache | Yes No  |
| Loss of vision Yes No  | Ocular trauma | Yes No  |
| Flashes, floaters, shadow Yes No  | Contact lens wear  | Yes No  |

**OTHER FINDINGS:**

|  |  |
| --- | --- |
| **CURRENT REFRACTION & VA:**  |  **Date:**  |
| Distance: R  | L  |
| IOP: R  | L  |

**PREVIOUS OCULAR HISTORY:**

**PROVISIONAL DIAGNOSIS:**

**FAX TO:0116 204 7860**

**Optometrist’s signature:**

Print name:

GOC No:

Date:

✁

Savant7125297.jw

**EYE CASUALTY REPLY SLIP**

Patient Name:

Date of Birth:

Date Seen in Eye Casualty:

Diagnosis:

Treatment:

Follow up:

Clinician’s Signature:

Print name: