

EAST SURREY HOSPITAL
EYE CASUALTY REFERRAL FORM

**ALL SECTIONS MARKED * ARE MANDATORY AND MUST BE COMPLETED OR YOUR
REFERRAL WILL BE REJECTED**

Referral source (e.g. GP surgery/Optician)													
Referral date*													
Patient's name*													
Patient's DOB*													
Patient's address													
Patient's contact tel*													
Patient's NHS number													
Site of symptoms*	<input type="checkbox"/> Right eye <input type="checkbox"/> Left eye												
Visual acuity* <input type="checkbox"/> unaided <input type="checkbox"/> w/ glasses <input type="checkbox"/> w/ contacts	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 50%;">Right</td> <td style="text-align: center; width: 50%;">Left</td> </tr> <tr> <td style="text-align: center;">6 /__</td> <td style="text-align: center;">6 /__</td> </tr> <tr> <td style="text-align: center;">Count fingers</td> <td style="text-align: center;">Count fingers</td> </tr> <tr> <td style="text-align: center;">Hand movement</td> <td style="text-align: center;">Hand movement</td> </tr> <tr> <td style="text-align: center;">Perception of light</td> <td style="text-align: center;">Perception of light</td> </tr> <tr> <td colspan="2" style="text-align: center;"><i>Fill in Snellen chart value in or circle as appropriate</i></td> </tr> </table>	Right	Left	6 /__	6 /__	Count fingers	Count fingers	Hand movement	Hand movement	Perception of light	Perception of light	<i>Fill in Snellen chart value in or circle as appropriate</i>	
Right	Left												
6 /__	6 /__												
Count fingers	Count fingers												
Hand movement	Hand movement												
Perception of light	Perception of light												
<i>Fill in Snellen chart value in or circle as appropriate</i>													
Duration of symptoms*	<input type="checkbox"/> 1-2-3 days <input type="checkbox"/> 1 week <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> >1month												
Presenting symptoms* (delete as appropriate or tick only those present)	<input type="checkbox"/> pain <input type="checkbox"/> redness <input type="checkbox"/> discharge <input type="checkbox"/> photophobia <input type="checkbox"/> headache <input type="checkbox"/> double vision <input type="checkbox"/> flashes <input type="checkbox"/> floaters <input type="checkbox"/> epiphora (watery eye) <input type="checkbox"/> visual field defect <input type="checkbox"/> change in vision/distortion												
Past ocular history* (delete as appropriate or tick only those present, leave blank if nil)	<input type="checkbox"/> Eye surgery/injection (less than 4/52) <input type="checkbox"/> Contact lens wearer <input type="checkbox"/> Trauma <input type="checkbox"/> Previous herpes zoster ophthalmicus <input type="checkbox"/> Previous herpes simplex <input type="checkbox"/> Uveitis/iritis <input type="checkbox"/> Glaucoma <input type="checkbox"/> Wet AMD <input type="checkbox"/> Diabetic retinopathy												
Relevant examination findings and additional info* (e.g. lid swelling, pupils/RAPD, ocular movements, visual fields)													
Treatment* (any therapy tried so far)													
PMHx and DHx													

This section is for the use of Eye Casualty staff only

For review in eye cas

- Same day review in-hours/out of hours
- Eye cas review within 24 – 48 hours
- Routine eye cas review within 1 week
- Routine eye cas review within 2 weeks

Not for eye cas

- Refer to specialist clinic: MR/VR/Glaucoma/Paeds
- Routine general clinic app within ____ weeks

Reject back to referrer

- More information required
- Inappropriate referral (for other specialty or GP to follow up)