All sections marked with **(\*) are compulsory** and your referral will be rejected if it does not meet the requirements. **Please email completed referral to** [**eye.clinic@nhs.net**](mailto:eye.clinic@nhs.net)

|  |  |  |  |
| --- | --- | --- | --- |
| Referral Organisation |  | | |
| Organisation Address |  | | |
| Organisation Email |  | | |
| Referral date |  | | |
| **Patient’s name\*** |  | | |
| NHS No |  | **DOB** |  |
| **Address\*** |  | | |
| **Contact tel\*** | H: M: | | |
| **Site of symptoms\*** | Right eye  Left eye | | |
| **Visual acuity\*** | Right: Left:  Uncorrected  With glasses/contact lenses | | |
| **Duration of symptoms\*** | 1-2-3 days  1 week  1-2 weeks  >1month | | |
| **Presenting symptoms\*** | pain  redness  discharge  photophobia  headache  double vision  flashes  floaters  epiphora (watery eye)  visual field defect  change in vision/distortion | | |
| **Past ocular history\*** | Eye surgery/injection (less than 4/52 ago)  Contact lens wearer  Trauma  Uveitis/iritis  Glaucoma  Wet AMD  Diabetic retinopathy  Previous herpes zoster ophthalmicus  Previous herpes simplex | | |
| **Examination findings\*** *(e.g. lid swelling, pupils/RAPD, ocular movements, visual fields)* |  | | |
| **Treatment \**(****details of any therapy tried so far)* |  | | |
| Any relevant past medical history incl current medication |  | | |
| Allergies |  | | |
| Any additional information |  | | |
| Referred by: |  | Role: |  |
| *This section is for the use of Eye Casualty staff only* | | | |
| Outcome | Same day review in-hours/out of hours  Routine eye cas review within 1 week  Routine eye cas review within 2 weeks  Not for eye cas – refer to specialist clinic | | |