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**

|  |  |
| --- | --- |
| 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 |