GOS18 Ophthalmic Referral/Information for GP

Date of sight test **Date of referral (if different)**

Optometrist/OMP Name and Practice Address	**Patient details**
Post Code: Tel: NHS Mail:	Title «title» Gender M / F Surname «surname» Forenames «firstnames» Address «address1» «address2» «address3» «town» Post Code: «postcode» Telephone: «telhome» Date of Birth «dateofbirth» NHS Number (if known) «nhsnumber»
GP name and Practice Address «gpsname» «gpssurgery» «gpsaddress1» «gpstown» «gpspostcode»	

GP Action required: (Also see "additional information" below)	**ADULTS (16 or older): Clininc Type suggested (tick most urgent one)**	**CLINICAL TERM(S): Enter relevant keyword(s) (these are to help the GP to find correct HES service)**
☐ This letter is for INFORMATION ONLY ☐ Patient asked to telephone/visit GP ☐ Patient sent to Eye Casualty ☐ Advise Referral to Eye Dept (URGENT) ☐ Advise Referral to Eye Dept (Routine)	☐ Cataract ☐ Cornea ☐ Diabetic Medical Retina ☐ External Eye Disease ☐ Glaucoma ☐ Laser (YAG capsulotomy) ☐ Low Vision ☐ Oculoplastics/Orbits/Lacrimal ☐ Other Medical Retina (incl ARMD) ☐ Squint/Ocular Motility ☐ Vitreoretinal ☐ Not Otherwise Specified	_____ _____ _____ _____
CHILDREN: Clinic Type suggested for referral to HES (tick most urgent one) ☐ Strabismus and Amblyopia ☐ Paediatric non-strabismus ☐ Orthoptic (only)		

	Sph	Cyl	Axis	Prism	Base	VA	Pinhole	Add	Near Vision	Previous corrected VA on (Date)
Right	«rsphere»	«rcyl»	«raxis»	«rdisthoriprism» «rdistvertprism»	«rdisthoribase» «rdistvertbase»	«rva»		«radd»	«rnearva»	
Left	«lsphere»	«lcyl»	«laxis»	«ldisthoriprism» «ldistvertprism»	«ldisthoribase» «ldistvertbase»	«lva»		«ladd»	«lnearva»	

	Right Eye	**Left Eye**	
Visual Fields	Normal/enclosed (if abnormal)	Normal/enclosed (if abnormal)	
Optic nerve heads	C:D	C:D	
Intraocular pressure Time	mm HG	mm HG	Applanation / non contact / Other NCT
Additional Information		Cycloplegic refraction	Dialated fundus examination

GOS 18 Part One – This part must accompany any referral made to an Eye Department

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 Services, their General Medical Practitioner, and optometrist or ophthalmic medical practitioner (delete any not considered to).

If appropriate, Guardian's name and address

Signed (optometrist/OMP) GOC/GMC No