

Date of sight test

Date of referral (if different) .....

<p><b>Optometrist/OMP Name and Practice Address</b></p>	<p><b>Patient details</b></p> <p>Title: «title»                      Gender: «gender»</p> <p>Surname: «surname»</p> <p>Forenames: «firstnames»</p> <p>Address: «address1» «address2»</p> <p style="text-align: center;">«town» «postcode»</p>
<p>NHS mail:</p>	<p>Telephone: «telhome»</p>
<p><b>GP Name and Practice Address</b></p> <p>«gpsname»</p> <p>«gpssurgery»</p> <p>«gpsaddress1»</p> <p>«gpsaddress2»</p> <p>«gpstown»</p> <p>«gpspostcode»</p>	<p>Date of Birth «dateofbirth»</p>
	<p>NHS Number (if known) «nhsnumber»</p>

<p><b>GP Action required:</b> (Also see "additional information" below)</p> <p><input type="checkbox"/> This letter is for INFORMATION ONLY</p> <p><input type="checkbox"/> Patient asked to telephone/visit GP</p> <p><input type="checkbox"/> Patient sent to Eye Casualty</p> <p><input type="checkbox"/> <b>Advise Referral to Eye Dept (URGENT)</b></p> <p><input type="checkbox"/> Advise Referral to Eye Dept (Routine)</p> <p style="text-align: center;"><b>CHILDREN: Clinic Type suggested for referral to HES (tick most urgent one)</b></p> <p><input type="checkbox"/> Strabismus and Amblyopia</p> <p><input type="checkbox"/> Paediatric non-strabismus</p> <p><input type="checkbox"/> Orthoptic (only)</p>	<p><b>ADULTS (16 or older): Clinic Type suggested (tick most urgent one)</b></p> <p><input type="checkbox"/> Cataract</p> <p><input type="checkbox"/> Cornea</p> <p><input type="checkbox"/> Diabetic Medical Retina</p> <p><input type="checkbox"/> External Eye Disease</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Laser (YAG capsulotomy)</p> <p><input type="checkbox"/> Low Vision</p> <p><input type="checkbox"/> Oculoplastics / Orbits / Lacrimal</p> <p><input type="checkbox"/> Other Medical Retina (incl ARMD)</p> <p><input type="checkbox"/> Squint / Ocular motility</p> <p><input type="checkbox"/> Vitreoretinal</p> <p><input type="checkbox"/> Not Otherwise Specified</p>	<p><b>CLINICAL TERM(S):</b></p> <p>Enter relevant keyword(s) (these are to help the GP to find correct HES service)</p>
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	Sph	Cyl	Axis	Prism	Base	VA	Pinhole	Add	Near Vision	Previous corrected VA on (date)
<b>Right</b>										
<b>Left</b>										

	<b>Right eye</b>	<b>Left eye</b>	
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

Additional information

Cycloplegic refraction       Dilated fundus examination

**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 Service, their General Medical Practitioner, and optometrist or ophthalmic medical practitioner (delete any not consented to).

If appropriate, Guardian's name and address \_\_\_\_\_