GOS REFERRAL */NOTIFICATION* FORM **(*Delete as appropriate)**

To be completed by GOS Practitioner (part A), Patient (part B), and GM Practitioner (part C)

PATIENT'S NAME & ADDRESS	GOS PRACTITIONER	MEDICAL PRACTITIONER
Name: «Title» «FirstNames» «Surname» Address: Postcode: Tel. Home:	From	To

PART A

	RIGHT								LEFT						
PRESCRIPTIONS FROM PREVIOUS SIGHT TEST	Vision	Sph	Cyl	Axis	Prism	Base	V/A		Vision	Sph	Cyl	Axis	Prism	Base	V/A
								Distance							
DATE:_____								Reading							
PRESCRIPTIONS FROM CURRENT SIGHT TEST								Distance							
								Reading							
_____								Cycloplegic Results							

INFORMATION

INTRAOCULAR PRESSURES		OPTIC DISCS		VISUAL FIELDS	
Rt_____mm Hg	Lt_____mm Hg	Rt_____	Lt_____	Rt_____	Lt_____
@_____am/pm	@_____am/pm			_____	_____

TANOMETER

Field plot attached YES/NO

THIS PATIENT HAS BEEN ASKED TO:		**RECOMMENDED COURSE OF ACTION:**		**URGENCY RATING:**	
Make an appointment to see you	☐	Optometrists Signature_____	Investigation/treatment by GP	☐	ROUTINE ☐
		List Number_____	Refer to Hospital Eye Department	☐	SOON ☐
Report directly to hospital as an emergency case	☐	Date_____	No action (information only)	☐	URGENT ☐

PART B – TO BE COMPLETED BY PATIENT

I agree/do not agree that any Ophthalmologist to whom I am referred for medical consultation or treatment may make information relevant to my eye condition and its treatment, available to my General Ophthalmic Services Practitioner.

Patient's Signature_____

Date_____

PART C – BY GENERAL MEDICAL PRACTITIONR (when referring to Hospital Eye Department)

Tick if the patient is Diabetic ☐

Signature:_____ Date:_____ Cyper No:_____ Fundholding Code:_____