WECS(3)

Referral Form: Optometry to Ophthalmology

Principle Reason for Referral .... **EMERGENCY / PRIORITY / IN TURN**

GIG CYMRU NHS WALES

Patient Details

Title: Mr / Miss / Mrs / Ms / Dr / Other: .... Sex: M / F

Surname: «surname» Forenames: «firstnames»

Address: «address1» «address2»

«town» «county»

Postcode: «postcode»

DOB: «dateofbirth» NHS / Hosp No. (if known) «nhsnumber»

Tel. Number(s) E Mail Address «telhome»

Interpreter: Required / Not required Language ....

Optometrist Practice (Capitals or Stamp)

Date of examination: ....

Date of Referral: ....

Findings and Provisional Diagnosis:

-
-
-
-
-

Cataract Referral: Will patient undergo cataract surgery? Y / N Refractive change? Y /N (see below)

Right ☐ Left ☐ Driver ☐ Working ☐ Carer ☐ Lifestyle Compromised ☐ Safety Problem ☐

	Disc features	IOP (mmHg)	Time	Field defect	Enclosure	Macula features
R				Y / N	Y / N	
L				Y / N	Y / N	

Relevant Family Ocular History:

Patient General Health information (Incl. known allergies)

Known conditions:

Known medication:

	Vision	SPHERE	CYL	AXIS	PRISM / BASE	**VA**	**PH**	ADD	**NEAR VA**	PREVIOUS Rx	BEST VA	DATE
R	«rvaunaided»	«rsphere»	«rcyl»	«raxis»	«rdisthoriprism» «rdisthoribase» «rdistvertprism» «rdistvertbase»	«rva»		«radd»	«rnearva»			«rxdate»
L	«lvaunaided»	«lsphere»	«lcyl»	«laxis»	«ldisthoriprism» «ldisthoribase» «ldistvertprism» «ldistvertbase»	«lva»		«ladd»	«lnearva»			«rxdate»

Signed .... (Optometrist) Print Name «rxoptician» Ophth. List No .... Date ....

For the attention of Dr .... of .... Surgery/H.C.

I AM REFERRING THIS PATIENT TO OPHTHALMOLOGY AS INDICATED BELOW and informing you as required

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Mr/Mrs/Miss/Dr ………………………… of ………………………… Hospital.

Hospital Copy ☐	Optometrist Copy ☐	GP Copy ☐
(for referral purposes)	(for Records)	(for information: **do not forward to HES)**