Practice Logo **Optoms Names** Practice Address

REFERRAL / INFORMATION FORM

Mr / Mrs / Ms / Master	First Name:	Surname	
	«firstnames»	«surname»	DOB: «dateofbirth» Male ☐ Female ☐

Address «address1» «address2» «town» Post Code: «postcode»

Dear «gpsname», «gpssurgery», «gpstown», «gpspostcode»

Reason for Referral

GP Action required:

- ☐ 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)

CHILDREN: Clinic Type

- ☐ Strabismus and amblyopia
- ☐ Paediatric non-strabismus
- ☐ Orthotic (only)

ADULT (16 or Older): Clinic Type

- ☐ Cataract Laser (YAG capsulotomy)
- ☐ Cornea
- ☐ Diabetic Medical Retina
- ☐ External Eye Disease
- ☐ Glaucoma
- ☐ Low Vision
- ☐ Neuro-ophthalmology
- ☐ Oculoplastics / Orbits / Lacrimal
- ☐ Other Medical Retina (incl ARMD)
- ☐ Squint / Ocular motility / Orthoptic
- ☐ Vitreo-retinal
- ☐ .....

CLINICAL TERM(S):
Enter relevant keyword(s)
These are to help the GP to correct HES service

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Rx	Unaided Vision	Sph	Cyl	Axis	Prism	Base	VA	Pinhole	Add +	Near	Previous Corrected VA on Date:
R	«rvaunaided»	«rsphere»	«rcyl»	«raxis»	«rdisthoriprism» «rdistvertprism»	«rdisthoribase» «rdistvertbase»	«rva»		«radd»	«rnearva»	
L	«lvaunaided»	«lsphere»	«lcyl»	«laxis»	«ldisthoriprism» «ldistvertprism»	«ldisthoribase» «ldistvertbase»	«lva»		«ladd»	«lnearva»	

OCULAR EXAMINATION

	Right Eye		Left Eye		
Visual Fields / Amsler	Normal / Enclosed (if abnormal)		Normal / Enclosed (if abnormal)		
Optic Nerve Heads	C:D		C:D		
Intraocular Pressure Time:	mm Hg	CCT	mm Hg	CCT	Applanation ☐ Non Contact ☐

Additional Information: Cycloplegic Refraction ☐ Dilated Fundus Examination ☐

Signature……

Statement: The reason for this referral has been made clear to the patient or guardian who agrees to it.
The patient or guardian also consents to information being exchanged between the HES/GP/Optometrist.

Date……