EYE EXAMINATION APPOINTMENT PRIORITY FORM – COVID19 SCREENING

Patient Name	DOB	Telephone No	Date	Time

Please give a brief description of the problem

COVID-19 SCREENING QUESTIONS (**please circle**):

- Have you travelled abroad within the past 2 months?	YES which country:	NO
- Have you had a cough or fever within the past 3 weeks?	YES	NO
- Has anyone in your household had a cough/fever within the past 3 weeks?	YES	NO
- Do you suffer from COPD or chest/respiratory problems?	YES	NO

PLEASE **CIRCLE** THE FOLLOWING

Who referred patient	Self-referred	GP referral	Pharmacy	Optom	Other

Duration of symptoms	24 hours	2-3 days	1 week	2 weeks	1 month+

Which eye is affected	Right eye	Left eye	Both eyes

How much pain do you have	None	Mild	Moderate	Severe

Is the vision affected	No	Blurred	Patch/curtain	Distorted	Total loss

Is there any discharge	None	Watery	Gunky

Any other problems	Red eye	Floaters	Flashes	Double vision	Sensitive to light	Contact lenses

Last examination date:	Patient of this practice: YES NO	Where is the patient? Home / GP / Hospital / In practice

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OPTOMETRIST TO ACCION – PLEASE CIRCLE

Appointment advice	Now	Today	Next Day	Routine/non-essential

Plan of action	App this practice	App other practice	Go to GP/Ring GP	Go to A&E	Call 111

Advice to patient:	Not to drive	Not to wear CLs	Bring meds/paperwork

Optical assistant name:	Optometrist name:	Date:	Time: