|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 1 - PATIENT INFORMATION** **- Mandatory (Please complete in BLOCK CAPTIALS)** | | | | | | | | | | | | | | | | | |
| SURNAME | | |  | | | | | | DATE OF BIRTH | | |  | | | | | |
| FIRST NAME | | |  | | | | | | NHS NUMBER | | |  | | | | | |
| ADDRESS | | |  | | | | | | HOME TEL NO | | |  | | | | | |
| MOBILE TEL NO | | |  | | | | | |
| EMAIL ADDRESS | | |  | | | | | | | | | | | | | | |
| REGISTERED GP PRACTICE  NAME AND  ADDRESS | | |  | | | | | | | | | | | | | | |
| **Section 2 – OPTICAL PRACTICE INFORMATION – Mandatory** | | | | | | | | | | | | | | | | | |
| REFERRING OPTOMETRIST | | |  | | | | | | | | | | GOC NO. | | |  | |
| OPTICAL PRACTICE  NAME & ADDRESS | | |  | | | | | | | | | | | | | | |
| TELEPHONE NO | | |  | | | | | NHS.NET EMAIL | | |  | | | | | | |
| **Section 3 – REQUIREMENTS – Mandatory** | | | | | | | | | | | | | | | | | |
| **PRIORITY** | | | **ROUTINE** | EMAIL TO: [mlcsu.ophthalmologyroutine@nhs.net](mailto:mlcsu.ophthalmologyroutine@nhs.net) | | | | | | **URGENT** | EMAIL TO:  [mlcsu.ophthalmologyUrgent@nhs.net](mailto:mlcsu.ophthalmologyUrgent@nhs.net) | | | | | | |
| ***Please Note For:***  **FAST TRACK** *(AMD Fast Track)* - EMAIL TO: [practiceplusgrp.northwestmacular@nhs.net](mailto:practiceplusgrp.northwestmacular@nhs.net) | | | | | | | | | | | | | | | | | |
| **EMERGENCY** *(Requiring immediate / same day assessment only)* -Triage line Mon-Fri 9-5 call **01257  245346.** Out of hours/weekends Telephone 01772716565 and speak to On Call Ophthalmologist | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **REASON FOR REFERRAL** | | | | | | | | | | | | | | | | | |
| **Please Tick** | | | **Description / Clinic Type (Adult eye conditions)** | | | | | | | | | | | | | | |
|  | | | Cataract  *(if referring for Cataract please submit any additional conditions on a separate referral form)* | | | | | | | | | | | | | | |
|  | | | Cornea | | | | | | | | | | | | | | |
|  | | | Diabetic Medical Retina | | | | | | | | | | | | | | |
|  | | | External Eye Disease | | | | | | | | | | | | | | |
|  | | | Glaucoma | | | | | | | | | | | | | | |
|  | | | Laser (YAG capsulotomy) | | | | | | | | | | | | | | |
|  | | | Low Vision | | | | | | | | | | | | | | |
|  | | | Neuro-Ophthalmology | | | | | | | | | | | | | | |
|  | | | Not otherwise specified | | | | | | | | | | | | | | |
|  | | | Oculoplastics / Orbital / Lacrimal | | | | | | | | | | | | | | |
|  | | | Oncology (established diagnosis) | | | | | | | | | | | | | | |
|  | | | Orthoptics | | | | | | | | | | | | | | |
|  | | | Other Medical Retina | | | | | | | | | | | | | | |
|  | | | Squint/Ocular Motility | | | | | | | | | | | | | | |
|  | | | Vitreo Retinal | | | | | | | | | | | | | | |
| **Please Tick** | | | **Description/ Clinic type (Enhanced Community Offer)** | | | | | | | | | | | | | | |
|  | | | MECs | | | | | | | | | | | | | | |
|  | | | Glaucoma Referral Refinement | | | | | | | | | | | | | | |
|  | | | YAG Laser | | | | | | | | | | | | | | |
|  | | | Minor ops | | | | | | | | | | | | | | |
|  | | | **Description/ Clinic type (Children & Adolescent)** | | | | | | | | | | | | | | |
|  | | | Not otherwise specified | | | | | | | | | | | | | | |
|  | | | Orthoptics | | | | | | | | | | | | | | |
|  | | | Strabismus/Ocular Motility | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Section 4 – SIGHT TEST DETAILS** | | | | | | | | | | | **Date** | | |  | | | |
| **Refraction** | | | | | | | | | | | | | | | | | |
|  | | **Vision** | | **Sph** | **Cyl** | | **Axis** | | | **VA** | **Add** | | | | **Prism** | | **Base** |
| **Right** | |  | |  |  | |  | | |  |  | | | |  | |  |
| **Left** | |  | |  |  | |  | | |  |  | | | |  | |  |
|  | | | | | | | | | | | | | | | | | |
| **Previous VA (if known)** | | | | | | | | | | | | | | | | | |
| **Date** |  | | | | **Right** |  | | | | | **Left** | | |  | | | |
|  | | | | | | | | | | | | | | | | | |
| **Tonometry and Disc Assessment** | | | | | **Right** | | | | | | **Left** | | | | | | |
| IOP Average | | | | |  | | | | | |  | | | | | | |
| Instrument | | | | |  | | | | | |  | | | | | | |
| Time | | | | |  | | | | | |  | | | | | | |
| Optic Disc Description  [Size, ISNT, PPA, Haem, CDR, etc] | | | | |  | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Section 5 - REFERRAL INFORMATION** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **PLEASE NOTE**  **All fields are mandatory. Please enter ‘N/A’, ‘New Patient’, ‘Not assessed’ or similar if necessary.**  **Incomplete forms may be returned to the originating referrer if the referral cannot be processed.** | | | | | | | | | | | | | | | | | |