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| **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 ANDADDRESS |  |
| **Section 2 – OPTICAL PRACTICE INFORMATION – Mandatory** |
| REFERRING OPTOMETRIST  |  | GOC NO. |  |
| OPTICAL PRACTICENAME & ADDRESS |  |
| TELEPHONE NO |  | NHS.NET EMAIL |  |
| **Section 3 – REQUIREMENTS – Mandatory** |
| **PRIORITY** | **ROUTINE** | EMAIL TO: mlcsu.ophthalmologyroutine@nhs.net |  **URGENT** | EMAIL TO: mlcsu.ophthalmologyUrgent@nhs.net |
|  ***Please Note For:***  **FAST TRACK** *(AMD Fast Track)* - EMAIL TO: 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.** |