DATE: / / / **1st Assessment O** **2nd Assessment O**

Patient Address:	D O B: / / / Age:

Risk Factors: Parent O Sibling O Child O Afro Caribbean O Other O
Medication:

R	CLINICAL INFORMATION	L
mmHg	Applanation IOP Time:	mmHg
Defect / suspicious / No Defect.	Visual Field	Defect / suspicious / No Defect
	Van Herrick grade	
	Krukenberg / pseudoexfoliation	

	L M S	**Disc size**	**L M S**
		Vertical C/D ratio	
	VO / HO / R	**Cup shape**	**VO / HO / R**
		ISNT rule? (SINT, NIST, ETC)	
	Y / N Y / N **Y / N**	**Focal Notch** (Position reflects field defect?) **Peri-Papillary Atrophy?**	**Y / N** Y / N **Y / N**
	Y / N	**Disc haemorrhage/** **Vessel baring / nipping?** **(Draw** *any unusual features*)	**Y / N**

NORMAL / OHT / GLAUCOMA		NORMAL / OHT / GLAUCOMA

ACTION TAKEN (If *2nd assessment refer to HES or discharge to GOS follow up only*)

1. Refer as Glaucoma suspect to HES O
2. Repeat Fields & IOP within 4/52 O
3. Routine recall under GOS O

GP Address:	Optometrist: Address: **Signature**

This form may be used for your own records, and may be used to refer your patient to secondary care.

If referring, then send direct to the patient's chosen hospital after offering choice. Do not send via SPA or the GP.