

## General Ophthalmic Services – Referral of Patient

<b>PATIENT DETAILS</b>		Title Mr	Surname	Forename(s)	
DOB	NHS No			<input type="checkbox"/> U 16	<input type="checkbox"/> Protected Address
Address					
Postcode		Tel 1		Tel 2	

<b>OPTOM DETAILS</b>	Tel	Fax
Address		
Postcode	NHSmial	

<b>GP DETAILS</b> Dr	Tel
Address	
Postcode	

<b>REFERRAL REASON</b> (Denote with x)		
<input type="checkbox"/> Cataract Only	<input type="checkbox"/> Glaucoma/Ocular Hypertension	<input type="checkbox"/> Unexplained Headaches
<input type="checkbox"/> Cataract with co-pathology	<input type="checkbox"/> Binocular Anomaly / Amblyopia	<input type="checkbox"/> Unexplained Drop in VA
<input type="checkbox"/> Post-Cataract Complications	<input type="checkbox"/> Red Eye / Conjunctivitis	<input type="checkbox"/> Field Defect
<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Dry Eye / Epiphora / Lids	<input type="checkbox"/> AMD
	<input type="checkbox"/> PVD / Ret Detach Symptoms	<input type="checkbox"/> Other (see further information)

<b>ACTION REQUIRED</b>	<b>INFORMATION FOR GP</b>	
<input type="checkbox"/> Referral Required – Urgent (see further information)	<input type="checkbox"/> Px sent To Eye Casualty	<input type="checkbox"/> Optometrist To Manage
<input type="checkbox"/> Referral Required – Routine	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Px Told To Contact GP
	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Other (see further information)

<b>Eye Examination Date</b>		<input type="checkbox"/> Cycloplegic Refraction	<input type="checkbox"/> Dilated Fundus Examination						
	SPH	CYL	AXIS	PRISM	VA	PH	ADD	PRISM	N VA
R									
L									

Previous VA Date	R	L	GRR / CATS	<input type="checkbox"/> Not Done	<input type="checkbox"/> Done
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<b>DISCS</b>	R C/D	L C/D
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<b>IOP / mmHg</b>	Contact/NCT	R	L	Time
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<b>VISUAL FIELDS</b>	R	L
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<b>FURTHER INFORMATION</b>

The reason for this referral has been explained to the patient or guardian who agrees to it. The patient or guardian also consents to information being exchanged between the Hospital Eye Service, their General Medical Practitioner, and optometrist or ophthalmic medical practitioner.

If guardian's name and/or address different from the above please give it here:

Signed Optom/OMP	Referral Date	GOC Number
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For patients with a Sheffield GP, please send referral to Single Point of Access (Ophthalmology Referrals), Community House, Northern General Hospital, Herries Road, Sheffield S5 7AU, FAX 0114 3051461, 0114 3051462 or 01143051463 email [sh-t-tr.SPA@nhs.net](mailto:sh-t-tr.SPA@nhs.net) (via nhs mail only), unless GRR/CATS done, or emergency referrals, then send straight to secondary care. For a non-Sheffield GP, refer via GP, or emergency referrals straight to secondary care.