**Emergency Eye Clinic Referral Form**

To be Completed by Community Optometrist / GP

Please note all fields are mandatory and should be completed electronically. Incomplete forms will be returned and may result in delays.

**Please ensure Eye Casualty Referral is appropriate. See** [**here**](http://rms.kernowccg.nhs.uk/primary_care_clinical_referral_criteria/opthamology) **for guidance**

(http://rms.kernowccg.nhs.uk/primary\_care\_clinical\_referral\_criteria/ophthalmology)

|  |  |
| --- | --- |
| **Patient Details** | |
| Name: Click here to enter text. | Date of birth: Click here to enter text. |
| Address: Click here to enter text. | Phone number: Click here to enter text. |
| Post code: Click here to enter text. | NHS (if known): Click here to enter text. |
| **GP and Optometrist Details** | |
| GP Name: Click here to enter text. | Surgery address: Click here to enter text. |
| Optometrist Name: Click here to enter text. | Practice address: Click here to enter text. |
| **Referrer Details** | |
| Referrer Name: Click here to enter text. | Referrer contact: Click here to enter text. |
| Date of Referral: Click here to enter text. | Time of Referral: Click here to enter text. |

**History of Presenting Complaint**

|  |
| --- |
| Click here to enter text. |

**Ocular history**

|  |
| --- |
| Please include prior surgery and other eye history:  Click here to enter text. |

**Medical History**

|  |
| --- |
| Please insert text or attach a patient profile ( patient to bring a list of medications):  Click here to enter text. |

**Symptoms**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Right | | | | | | | Left | | | | | | | | | | | Both | | | | | | |
| How long has the patient had symptoms for? | | | | | | | | | | | | | | | | | | | | | | | | |
| For Click here to enter text. days **OR** Click here to enter text. months | | | | | | | | | | | | | | | | | | | | | | | | |
| Pain score (0 = none, 10 = worst imaginable) | | | | | | | | | | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | | | 3 | | | 4 | | | 5 | | 6 | | | 7 | | | 8 | | | | 9 | 10 |
| Photophobia | | | None | | | | | | Mild | | | | | Moderate | | | | | | | Severe | | | |
| Redness | | | None | | | | | | Mild | | | | | Moderate | | | | | | | Severe | | | |
| Loss of vision | | | None | | | | | | Blurred | | | | | Partial | | | | | | | Total | | | |
| Visual Acuity unaided  (if no glasses) | | | | | | R: Click here to enter text. | | | | | | | | | | | L: Click here to enter text. | | | | | | | |
| Visual Acuity with glasses | | | | | | R: Click here to enter text. | | | | | | | | | | | L: Click here to enter text. | | | | | | | |
| Visual Acuity with pinhole | | | | | | R: Click here to enter text. | | | | | | | | | | | L: Click here to enter text. | | | | | | | |
| Gross fields intact? | | | | | | Y | | | | | | N | | | | | Specify Defect Click here to enter text. | | | | | | | |
| Contact lens wearer | | | | | | Y | | | | | | N | | | | |  | | | | | | | |
| Double vision | | | | | | Y | | | | | | N | | | | | Monocular or Binocular (disappears when one eye closes) delete as appropriate | | | | | | | |
| Flashers, Floaters, Dark veil | | | | None | | | | | | Sudden | | | | | Recent | | | | | | | Old | | |
| Discharge | | | | None | | | | | | | | Watery | | | | | | | | Purulent | | | | |
| Trauma | | | | None | | | | | | | | Mechanical | | | | | | | | Chemical | | | | |

|  |  |  |
| --- | --- | --- |
| Symptoms of Giant Cell arteritis? (If no visual symptoms referral is via Rheumatology) | Y | N |
| FBC ESR CRP bloods taken? | Y | N |

**Royal Cornwall Hospital Trust**

**The Eye Unit, Ground Floor, Tower Block, Treliske Hospital, Truro, TR1 3LJ**

Telephone Number between 08:00-17:45 01872 253788

Treliske Switchboard out of hours 01872 250000

**Referrer – Please now send this referral to** [rch-tr.EmergencyEyeClinic@nhs.net](mailto:rch-tr.EmergencyEyeClinic@nhs.net) **If you are not referring from a GP surgery please send a copy of this form to the patient’s GP for their information. Thank you.**