**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 **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.**