|  |  |
| --- | --- |
| **Patient referral by a registered dispensing optician** |  |
| **To:**  | **Date:**  |
| **Practice / Hospital address:**  |
|  |
| **Px title:**  | **Surname:**  | **Other name**(s)**:**  |
| **Address:**  |
|  | **Postcode:**  | **Tel:**  |
| **D.O.B.**  | **NHS No.**  | **Mobile:**  |
| **Details from most recent sight test** (*if known*) | **Date of last sight test:**  |
|  | **VA** *Uncorrected* | **Sph** | **Cyl** | **Axis** | **Prism** | **Base** | **VA***At test* | **VA***Today* | **Add** | **VA***Near* |
| **RE** |  |  |  |  |  |  |  |  |  |  |
| **LE** |  |  |  |  |  |  |  |  |  |  |
| **Further details of eye exam if known from previous records** |
| **Intraocular Pressure (mmHg)** | **RE:**  | **LE:**  | **Method:**  |
| **Visual Fields** | **RE:**  | **LE:**  | **Method:**  |
| **Points requiring attention – for information (and possible referral)****Gross examination (signs):** I did / did not examine using a slit lamp bio-microscope (*delete as appropriate*)**Symptoms and duration:****Relevant details of Px history:**(*Delete as appropriate*):Please treat this referral as: an emergency / urgent / routine I have included current screening test results if appropriate / available I am referring directly as it is the most appropriate course of action / no optometrist is available● *Please note: as a dispensing optician I cannot perform ophthalmoscopy*  |
| **Signed:**  | **GOC number:**  |
| **Optician’s name and qualifications:**  |
| **Practice address:**  |
|  |
| **Tel:**  | **Email:**  |

**Copies to:** File / Px / A&E / GP / ophthalmologist / orthoptist / specialist optometrist (*delete as appropriate*)

**Sent:** Via post / by hand / with patient / electronically (*delete as appropriate*) and add details if fax or email:

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