|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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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