Spire
Norwich Hospital

Ophthalmology referral

Title:	First name:
Surname:	Date of birth:
Full address:	
Postcode:	
Telephone number:	Mobile number:

GP name:	
GP practice address:	

Optometrist name:	Phone number:
Optometrist address:	

Reason for referral (please tick)											
	Cataract	Cornea	Emergency eye care	Glaucoma	Medical retina	Neuro-ophthalmology	Oculoplastics	Paediatric	Uveitis	Vitreoretinal	YAG Capsulotomy
RE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Examination findings date:

	UAVA	Sph	Cyl	Axis	Prism	BCVA
RE	☐	☐	☐	☐	☐	☐
LE	☐	☐	☐	☐	☐	☐

Optic disc	RE	LE	IOPs		RE	LE
Appearance			☐ NCT	☐ Applantation		
C:D			Time:			

Visual fields	RE	LE
If abnormal please attach copies of visual fields		

OCT retinal scan images attached	
☐ Yes	☐ No

Additional information required for eye with cataract and better than 6/12 BCVA:						
Symptoms/condition	Yes	No		Symptoms/condition	Yes	No
Glare, halos or starburst	☐	☐		Anisometropia	☐	☐
Occupation issues	☐	☐		Co-existing eye conditions	☐	☐
Reading difficulty	☐	☐		Refractive shift due to cataract	☐	☐

Additional information

The patient has been informed and provides consent to the reason for this medical referral. Consent has also been obtained from the patient or guardian for medical correspondence relating to the treatment and management of referral being shared between consultant and GP, optometrist or ophthalmic medical practitioner. ☐

Signed:	GOC/GMC number:	Date: