**URGENT EYE CLINIC REFERRAL FORM**

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| **Patient Details** | | **Referrer Details** | | | |
| **First Name:**Click or tap here to enter text.  **Surname:**Click or tap here to enter text.  **DOB:**Click or tap here to enter text.  **Address:**Patient ward location if in-patient  **Postcode:**Click or tap here to enter text.  **Contact No:**Please make sure this is correct  **Email:**Optional | | **Name:**Click or tap here to enter text.  **Role:**Click or tap here to enter text.  **Department/Ward:**  **Address:**Click or tap here to enter text.  **Postcode:**Click or tap here to enter text.  **Contact No:**Click or tap here to enter text.  **Email:**Click or tap here to enter text. | | | |
|  | | | | | |
| **Is the patient an:** | **Inpatient** | | | **Outpatient** | |
|  | | | | | |
| **Presenting Complaint:**  Click or tap here to enter text. | | | | | |
| **Duration of Symptoms:** | **24-48 hours** | | **1 Week** | | **2 Weeks** |
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| **Visual Acuity:**  Best corrected vision should be tested in ALL patients if possible | **Right Eye**  Please choose an option or state why visual acuity was not assessed. | | | **Left Eye**  Please choose an option or state why visual acuity was not assessed. | |
| **Clinical findings and other relevant history: (please include IOP readings if available)**  Click or tap here to enter text. | | | | | |
| **Details of PHOTO / VISUAL FIELDS / SCANS: (please attach to referral if available)** | | | | | |
| **Save the form as a PDF and email to** [**enh-tr.urgenteyereferral@nhs.net**](mailto:enh-tr.urgenteyereferral@nhs.net)   * Please ensure that all fields are completed, incomplete forms will be rejected and returned to sender * This email is manned Monday – Friday 9am – 7pm and Saturday 9am – 12pm * We do not provide an urgent eye service outside of these hours   We will triage and contact the patient directly with an appointment or advise on alternative services  **Walk-in patients will be re-directed back to the referrer** | | | | | |
| **ABRIDGED REFERRAL GUIDE:**   1. This clinic is for adults and children that you feel have a **sight/life-threatening ophthalmological condition that requires hospital eye care within two weeks**  * Including but not exclusive: penetrating/severe blunt trauma, chemical injury, sudden loss of vision, acute severe pain, acute angle closure, sudden onset diplopia, acute post-op complications * **Routine referrals must not be sent via this pathway**  1. If you are unsure whether your patient fits the urgent criteria, please complete this form - it will be triaged according to clinical need | | | | | |