community eyecare
better care for local people

Shared Care Open access referral form for Optometrists

Date of Referral _____

PATIENT DETAILS:

Full Name:
Date of Birth:
Address:

Postcode:
Telephone number:

GP/Optom DETAILS:

GP Name:
GP Practice:

Optom Name:
Optom Practice:
Optom Address:

CLINICAL DETAILS:

Reason for referral: (please tick relevant box)

YAG ☐ CATARACT ☐ LID LUMPS ☐ OCULOPLASTIC ☐

GLAUCOMA ☐ MEDICAL RETINA ☐ VITREORETINAL ☐ OTHER ☐

Add free text:

Refraction

Right:						
	Sph	Cyl	Axis	VA	Add	Near VA
Left:						

☐	Cornea	☐
.....mmHg	IOP	.....mmHg
☐	Lens	☐
☐	Retina	☐
☐	Macula	☐
☐	Disc	☐

Add free text:

REFERRER DETAILS:

Optometrist Name..... Optometrist Practice.....

GOC number:.....

Transport Required ☐

Patient consent for Community Eyecare to request and exchange information with relevant medical professionals ☐ .....Patient signature