



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:						

<input type="checkbox"/>mmHg	Cornea	<input type="checkbox"/>mmHg
<input type="checkbox"/>		IOP	<input type="checkbox"/>	
<input type="checkbox"/>		Lens	<input type="checkbox"/>	
<input type="checkbox"/>		Retina	<input type="checkbox"/>	
<input type="checkbox"/>		Macula	<input type="checkbox"/>	
<input type="checkbox"/>		Disc	<input type="checkbox"/>	

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