Suffolk –Referral

Fax to 0207 692 4746

Only 1 patient per fax transmission

Patient Details	
Surname	
First Name	
Date of Birth	
Tel. Number	
Mobile Number	
Address	
Postcode	
NHS Number	
Dr.	
GP Surgery	
GP Address Suffolk PCT GPs Only	

Referring Clinician Details	
Name	
GOC Number	
Practice	
Address	
Date	

Action Required GP – For information only. evolutio to action all referrals to care provider

☐	Emergency – Referred direct to HES by Referrer
☐	Urgent – Within 2 Weeks
☐	Soon – Within 6 Weeks
☐	Routine – Within 18 Weeks
☐	GP appointment required
☐	ESO Self-Referral

Tonometry

	Reading 1		Reading 2	
	Right	Left	Right	Left
Date				
Time				
Instrument				
IOP Av.				

Referral Reason

☐	Cataract	☐	Child (<16 yrs)
☐	General	☐	Glaucoma
☐	Ocular Motility	☐	Lacrimal
☐	DMR	☐	External
☐	Low Vision	☐	Neuro
☐	OMR	☐	Vit Ret
☐	Cornea	☐	Orthoptics
☐	Laser YAG	☐	Other

Hospital Preference:	
ESO Preference:	

Prescription Details

	Vision	Sph	Cyl	Axis	VA	Add	Prism	Base
Right								
Left								

Previous Prescription Details **Date of Test:** 01-May-2012

	Vision	Sph	Cyl	Axis	VA	Add	Prism	Base
Right								
Left								

Observations: evolutio to send referral to appropriate provider. Info only for GP.

The patient's consent to information being exchanged has been obtained via the consent form	☐	Attachments Enclosed	☐

print

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