

This form is only for use where **GLAUCOMA ONLY** is suspected (either with or without LES level II provision) . This form should **NOT** be used where raised IOP is the only finding following LES Provision.

GLAUCOMA REFERRAL FORM

<p>OPTOMETRIST Name: GOS Personal code: Practice address:</p> <p>Signature: _____ Date: _____</p>	<p>GENERAL MEDICAL PRACTITIONER Name: Practice Address:</p>
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PATIENT DETAILS

Title:	Surname:	First Name(s):
Health & Care No:		Date of birth:
Address:		
Post code:		Tel No:
Date of Eye Examination:		Driver:
LES Level II Enhanced Case Finding provided:		Yes No

SYMPTOMS Asymptomatic Symptomatic (Please state symptoms)

Refraction and IOP Details Date: _____

	Unaided vision	Sph	Cyl	Axis	VA	Add	Near VA	Previous VA (state date)	IOP (state method and time)
R									
L									

<p>Disc Analysis: Optic Nerve Right</p> <p>V C:D Ratio: _____ Disc: _____</p> <p>Notch: <input type="checkbox"/> Disc Haemorrhage</p> <p>Dilated Indirect Disc Examination *Essential for LES Level II</p> <p>Yes No</p>	<p>Optic Nerve Left</p> <p>V C:D Ratio: _____ Disc: _____</p> <p>Notch: _____ Disc Haemorrhage:</p> <p>Dilated Indirect Disc Examination *Essential for LES Level II</p> <p>Yes No</p>
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Van Herick: RE: _____ (*must state and complete if Level II LES Provided) LE: Angle Status: _____

Angle Status: _____ Grade: _____

PDS: _____ Grade: _____ PDS: _____

PXF: _____ Gonioscopy _____ PXF: _____

Repeat Central Thresholding V/Fields Performed Visual Fields: Normal Defect: _____

* Essential for LES Level II

Attachment: _____ Field Plots _____ Fundus _____ OHT _____ HRT _____ GDx _____ (please tick all that apply)

<p>Relevant Findings/History e.g. cataract, family history, Raynaud's, Migraine</p>	<p>Reason for Referral – please tick all that apply</p> <p>IOP <input type="checkbox"/> Angle <input type="checkbox"/></p> <p>Discs <input type="checkbox"/> Visual Fields <input type="checkbox"/></p>
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PLEASE SEND THIS G1 REFERRAL FORM TO: **White copy to Clinic Blue copy to GP Yellow copy for patient record**

Optometry Practices in Belfast LCG area please send this G1 referral to the Glaucoma Service, Shankill Wellbeing and Treatment Centre, 83 Shankill Road, Belfast BT13 1FD. Optometry Practices in ALL other areas please send this G1 referral to the patient's General Medical Practitioner who will forward it to the appropriate ophthalmology clinic.

Date received by Glaucoma Service (for HES use only): _____