GOS REFERRAL*/NOTIFICATION* FORM (*Delete as appropriate)

GOS 18

To be completed by GOS Practitioner (part A), GM Practitioner (part B)

(Revised Nov 2013)

PATIENTS NAME & ADDRESS				GOS PRACTITIONER	MEDICAL PRACTITIONER
Name		Title			To
HCN		Address		GOS PRACTICE	
DOB					
Postcode					
Tel Home					
Tel Mobile					

PART A

		RIGHT								LEFT						
		Vision	Sph	Cyl	Axis	Prism	Base	V/A		Vision	Sph	Cyl	Axis	Prism	Base	V/A
PRESCRIPTION FROM PREVIOUS SIGHT TEST DATE:									Distance							
									Reading							
PRESCRIPTION FROM CURRENT SIGHT TEST:									Distance							
									Reading							
									Cycloplegic Results							

INFORMATION

INTRA OCULAR PRESSURES

Rt _____mm Hg @_____ am ○ pm ○

Lt _____mm Hg @_____ am ○ pm ○

TONOMETER TYPE _____

OPTIC DISCS

Rt _____ Lt _____

VISUAL FIELDS

Rt _____ Lt _____

_____ _____

Field plot attached ☐

THIS PATIENT HAS BEEN ASKED TO:

Make an appointment to see you ☐

Report directly to hospital as an emergency ☐

Optometrist Signature _____

List number _____

Date _____

RECOMMENDED COURSE OF ACTION:

Investigation/treatment by GP ☐

Refer to Hospital Eye Department ☐

No action (information only) ☐

URGENCY RATING:

ROUTINE ☐

SOON ☐

URGENT ☐

PART B – BY GENERAL MEDICAL PRACTITIONER (when referring to Hospital Eye Department)

Tick if the patient is Diabetic ☐

Signature: _____ Date: _____ Cypher No: _____