DIRECT OPTOMETRY - ORTHOPTIC REFERRAL FORM OP/OR1

To: (Orthoptic Clinic) _____
Trust:

Patient Name: **Address:** **Tel No:** **DOB:** **Health & Care no:** **GP Name:** **Address**	**Practitioner Name** **OO/OMP Code:** **Address:** **Tel No:**

Reason for referral

Px General Health **Px Family Hx**

Optometric Assessment

	RE	**LE**	
Unaided vision			**Vision test used:**
Full Retinoscopy (WD removed)			**Cyclo used:** ☐ **Yes/No** ☐ **Type:**
Glasses prescribed ☐ **Yes/No** ☐ If Yes give Rx			**Date prescribed:**
VA with glasses			**Date VA measured:**
Stereopsis Result: Test used:	**Cover Test** With/Without Rx	**Motility**	**Other tests**
Ophthalmoscopy			

Advice given to px

Signed (Optom/OMP) _____ **Date**_____

To be completed by patient/parent/guardian

I agree/do not agree that the clinican, to whom this referral is made, may make information on the outcome of my referral available to my General Ophthalmic Services practitioner.

Signature **Date**

ORTHOPTIC OUTCOME (to be returned to referring practitioner)

Date of Assessment:
Visual Acuity R L Test used:

Diagnosis

Action

Advice to patient

Glasses wear	Full time/Part time
Occlusion	
Review	

Patient management/review

Orthoptic clinic	
Refraction Clinic (HES/community)	
Refract under GOS in conjunction with orthoptic advice	
Discharge to practice	

Comments

Signed (orthoptist)_____

Name printed_____
Date_____

Clinic: **Contact tel no:**
Trust: