



Ophthalmology Referral

Fax to 0333 240 7729

Or NHS mail to LCHevolutio@nhs.net

Only 1 patient per fax transmission

Referral Type
Tick as appropriate

NHS

eCare Private

Patient Details	
Surname	
First Name	
Date of Birth	
NHS No.	
Tel. No.	
Mobile No.	
Address	
Postcode	
Dr	
GP Surgery	
GP Address	

Referring Clinician Details	
Name	
GOC No.	
Practice	
Address	
Referral Date	

Action Required	
<input type="checkbox"/>	Cancer – 2/52
<input type="checkbox"/>	Urgent – within 2/52
<input type="checkbox"/>	Routine – within 18/52

Referral Reasons	
<input type="checkbox"/>	Anterior Eye
<input type="checkbox"/>	Cataract
<input type="checkbox"/>	Cornea / Conjunctiva
<input type="checkbox"/>	External Eye Disease
<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	LVA Clinic
<input type="checkbox"/>	Neuro-Ophthalmology
<input type="checkbox"/>	Non Specific Eye Condition
<input type="checkbox"/>	Oculoplastics / Orbital / Lacrimal
<input type="checkbox"/>	Orthoptics
<input type="checkbox"/>	Paediatric (Under 18 months)
<input type="checkbox"/>	PCO / IOL (Incl. YAG)
<input type="checkbox"/>	Squint / Ocular Motility
<input type="checkbox"/>	Vitreo Retinal
<input type="checkbox"/>	Medical Retina (Incl. DMR)

Tonometry & Disc Assessment		
	Right	Left
Date / Time		
Disc Size		
ISNT Rule Followed		
Instrument		
IOP Avg.		

Local Pathway	
ESP Preference	
HES Preference	

	Vision	Sph	Cyl	Axis	VA	Add	Prism	Base
Right								
Left								
Previous VA →		Date		Right		Left		

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

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