Bedfordshire Optometrist Referral Form

PATIENT	
Name:	
DOB:	
Address	
Tel:	

GP	
Name:	
Address:	
Tel:	

OPTOMETRIST	
Name:	
Address	
Tel:	

Current Rx	Unaided Vision	Sph	Cyl	Axis	Prism	Corrected VA	Add	Near VA	IOP
Right									
Left									

Previous Rx Date:	Unaided Vision	Sph	Cyl	Axis	Prism	Corrected VA	Add	Near VA	Previous IOP
Right									
Left									

I have referred directly / please refer this patient to the following eye dept

Delete as appropriate

SYMPTOMS and SIGNS			
Disc Appearance	R	L	
Symptom Duration:		Asymptomatic Finding:	☐

Place a tick in the appropriate box

PROVISIONAL DIAGNOSIS	Visual Field Plot attached	Yes	☐	No	☐	
	Mydriasis	Yes	☐	No	☐	
ACTIONS / RECOMMENDATIONS	Routine	☐	Soon	☐	Urgent	☐
Patient has been informed and referral explained:		Yes	☐	No	☐	
Optometrists Signature:		Date:				
GP – Please enter NHS number and attach any relevant information on letter/printout. NHS Number:						