REFERRAL FOR ORTHOPTIC EXAMINATION

PATIENT DETAILS

Name: DOB: Current ward / department:

Address: Insert hospital sticker Consultant name:

Telephone: Hospital number:

Next of kin / alternative contact number: NHS number:

DETAILS OF CONDITION

Date of onset: Clinical diagnosis:

MRI / CT date and report:

OCULAR SYMPTOMS

- Double vision ☐
- Reading difficulties ☐
- Blurred / reduced vision (with glasses worn) ☐
- Visual field loss ☐
- Visual hallucinations ☐
- Visual awareness issues ☐
- Other (specify): ☐

Refer if positive for any symptoms / signs

OCULAR SIGNS

- Squint / turn of eyes ☐
- Ptosis (lid droop) ☐
- Defective eye movements ☐
- Abnormal pupils ☐
- Nystagmus (wobbling eyes) ☐
- Head turn ☐
- Visual inattention / neglect ☐
- Family concerns ☐
- Closing one eye ☐
- Misjudging distance ☐
- Suspected visual problem ☐
- Other (specify): ☐

OCULAR HISTORY

Are there any known pre-existing ocular conditions, e.g. cataract, glaucoma, retinopathy, macular degeneration, sight impaired registration? Note; this information is not a deterrent to referral.

GLASSES

Does the patient usually wear glasses? Y/N

Does the patient need glasses? Y/N

Does the patient have their glasses with them? Y/N

GENERAL INFORMATION

Indicate the level of basic functioning and cognition, and the presence of communication and general physical difficulties.

Expected date of discharge:
Where discharged to:

Can the patient walk to the eye clinic or come by wheelchair? Y/N

Does the patient require a ward visit? Y/N

Is the patient ready for immediate assessment? Y/N

Interpreter required? (specify language) Y/N

Signed: **Date:**

Print name: **Referrer Designation / Profession:**

Contact details of referrer:

Please complete as much of this form as possible

Based on: VIS UK. Eye, 2011;25(2):161-7.