REFERRAL REFINEMENT REPORT

To Dr: _____

Address: _____

_____

_____

Patient Name: _____

Address: _____

_____

Tel: _____ Postcode: _____

Date of Initial Examination: _____ / _____ / _____ *Please indicate reason(s) for second examination*

☐ Abnormal IOP R _____ L _____ mmHg ☐ Abnormal Visual Field ☐ Suspicion of Fundus Anomaly

Tier 1: Date and Time of 1st GAT _____ / _____ / _____ at ____ : ____ hr IOP R _____ L _____ mmHg

Date and Time of 2nd GAT _____ / _____ / _____ at ____ : ____ hr IOP R _____ L _____mmHg

Tier 2: Date of Refinement Examination _____ / _____ / _____

GAT IOP R _____ L _____ mmHg

Threshold Visual Fields Abnormal (plot enclosed)

Dilated Fundus Examination (details below) Mydriatic used: _____ % _____

	V	Sph	Cyl	Axis	Prism	VA	Add	NVA	Previous VA + Date
R									
L									

Disc Information: R C:D _____ L C:D _____ Abnormal

Visual Fields: Abnormal Plot enclosed? Yes ☐ No ☐

Further Information:

Has the Patient been told to make an appointment with a GP? Yes ☐ No ☐

Have glasses been dispensed? Yes ☐ No ☐

Optometrist Name: _____

Signature: _____

Date: _____ / _____ / _____

Optometrist Address or Stamp:

1. Copy GP ☐ 2. Copy Hospital Eye Service ☐ 3. Copy Optometrist ☐ 4. Copy Patient ☐