**Optometrist Direct Referral to Wetherby Eye Clinic**

**Please send all referrals to:**

**Wetherby Eye Clinic  
43 Market Place  
Wetherby LS22 6LN**

**Email: a.wetherby@nhs.net**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *We accept* ***non-urgent*** *adult referrals, including for glaucoma, ocular hypertension, external eye disease, blepharitis, watery and dry eyes, eyelid lesions excluding those with malignancy concerns, some minor surgery,* ***non-acute*** *flashers and floaters, retinal and optic disc problems* ***excluding emergencies****, dry age related macular degeneration, non-neurological blurred vision, pigmented iris and retinal lesions, painful eyes, and general ophthalmology conditions. Patients must be aged 17+.  For more information and exempt conditions see* [***www.applesonoptometrists.co.uk/wetherby-eye-clinic***](www.applesonoptometrists.co.uk/wetherby-eye-clinic) | | | | | | | | | | | | | | | | |
| **Patient Details** | | | | | | | | | | | | | | | | |
| Title | |  | | | Surname | |  | | | | First name(s) | |  | | | |
| Address | |  | | | | | | | | | | | Postcode | | |  |
| Date of Birth | | |  | | | NHS Number | | | |  | | Phone |  | | | |
| **Optometrist/OMP Details** | | | | | | | | | | | | Date of referral | | |  | |
| Name |  | | | | | | | | | | | GOC/GMC No | | |  | |
| Practice Address | | | |  | | | | | | | | Postcode | | |  | |
| Phone |  | | | | | | | Fax |  | | | Secure email | | |  | |
| **GP Details** | | | | | | | | | | | | | | | | |
| Name | | | |  | | | | | | | | Practice code | |  | | |
| Practice address | | | |  | | | | | | | | Postcode | |  | | |
| Phone |  | | | | | | | Fax |  | | | Secure Email | |  | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Visual Status** | | | | | | | | | | | Date: | | | | |
|  | SPHERE | CYL | | | AXIS | | PRISM | | **VA** | | ADD | | PRISM | | **NVA** |
| **RE** |  |  | | |  | |  | |  | |  | |  | |  |
| **LE** |  |  | | |  | |  | |  | |  | |  | |  |
| **Referral Reason** (please attach visual fields, photos, etc. if available) | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Other/Further Information | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Further Clinical Findings** | | | | | | | | | | | | | | | |
| Visual Fields | | | | RE | |  | | LE | |  | | Plot Attached | | |  |
| IOPs | | | | RE | |  | | LE | |  | | Method | | |  |
| *STATEMENT: The reason for this referral has been explained to the patient/guardian, who agrees to it. The patient/guardian also consents to information being exchanged between HES/GP/Optometrist* | | | | | | | | | | | | | | | |
| Optom/OMP Signature | | |  | | | | | | | | | Date | |  | | |