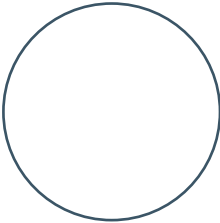
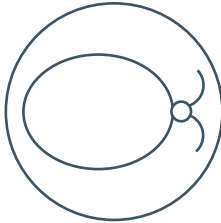
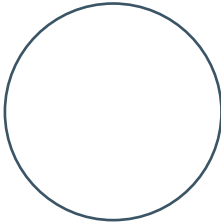
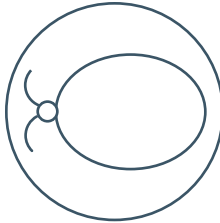


Referral To:

Location

Patient Details Name: _____ DoB: _____ Address: _____ _____ Email: _____ Postcode: _____ Tel: _____	Referral Type: ☐ Cataract ☐ Refractive ☐ Cornea ☐ Glaucoma ☐ Surgical Retina ☐ Medical Retina ☐ Oculoplastics Strabismus ☐ Other: _____ Date of referral: _____	Referring Optometrist Details: Name of Practice: _____ Name of Optometrist: _____ Address: _____ _____ Email: _____ Postcode: _____ Tel: _____
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RIGHT		LEFT	
Corneal	Fundus	Corneal	Fundus
			

*To draw on the above diagrams, select 'Comment' from your toolbar, then choose the Pen Icon.
Click here for additional information if necessary.*

Visual Acuity	Right eye: Distance		Near	Left eye: Distance		Near
Spectacle Prescription	SPH	CYL	AXIS	SPH	CYL	AXIS
I.O.P	Non Contact / Contact			Non Contact / Contact		

Additional Information / Comments:

☐ Copy of visual fields attached
☐ Copy of OCT attached

Optometrist to upload this form to the Eye Surgery Scotland website referral page.

<https://www.eyesurgeryscotland.com/clinical-referral-form>

Please retain a copy for your records. Following submission, a confirmation email will be returned to your address. If you do not receive this within 24 hours of submission please contact admin@eyesurgeryscotland.co.uk

Please click for conformation: I have the patients permission to retain their medical information and share it with Eye Surgery Scotland for clinical and medical useThe patient will not be contacted without their consent for any other reason than in follow up of their ongoing medical care and long term health benefits.