|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Norfolk & Norwich University Hospitals NHS Foundation TrustSuspect Glaucoma Direct Referral Form | | | | | | | | | | | | | | | | | | | | | | | |
| Email direct to NNUH: [OPServicesPostTeam@nnuh.nhs.uk](mailto:OPServicesPostTeam@nnuh.nhs.uk) (from an ‘@nhs.net’ address only) | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Details | | | | | | | | | | | | | | | | | | | | | | | |
| Title (Dr Mr Mrs Miss Ms) | | | Surname | | | | | | | | | | Other Names | | | | | | | | | | |
| Address | | | | | | | | | | | | | |  | | | | | | DoB: | | | |
|  | | | | | | | | | | | | | |  | | | | | | Phone: | | | |
|  | | | | | | | | | | | | | | Post Code | | | | | | Hosp No: | | | |
| Details of Current Sight Test | | | | | | | | | | | | | | | | | | | | Date: | | | |
|  | Vision | | Sph | | Cyl | | Axis | | | | | Prism | | | | | Add | | | VA | | | Near VA |
| Right Eye |  | |  | |  | |  | | | | |  | | | | |  | | |  | | |  |
| Left Eye |  | |  | |  | |  | | | | |  | | | | |  | | |  | | |  |
| Clinical Findings: Reasons for Suspecting Glaucoma | | | | | | | | | | | | | | | | | | | | | | | |
| ***Please circle or complete*** | | | | **Right Eye** | | **Left Eye** | | | | | | | | | |  | | | **Right Eye** | | | **Left Eye** | |
| Visual fields performed? | | | |  | |  | | | | | | | | | | IOP this visit:  Time: | | | mmHg | | | mmHg | |
| Visual field (enclose plot) | | | |  | |  | | | | | | | | | |  | | |  | | | | |
| Defect confirmed on repeat? | | | |  | |  | | | | | | | | | | Tonometer  Used | | | Goldmann  NCT model: \_\_\_\_\_\_\_\_\_\_\_\_  Perkins  iCare  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| C:D ratio / vertical disc size | | | | /       mm | | /       mm | | | | | | | | | |  | | |  | | | | |
| Optic Disc / Neuro-retinal rim | | | |  | |  | | | | | | | | | |  | | |  | | | | |
| Limbal AC depth | | | |  | |  | | | | | | | | | | Previous IOP:  Date & Time: | | | mmHg | | | mmHg | |
| If narrow, any symptoms? | | | |  | | | | | | | | | | | |  | | |  | | | | |
| If narrow, any “plus” factors? | | | |  | | | | | | | | | | | | | | | | | | | |
| Any other comments: | | | |  | | | | | | | | | | | | | | | | | | | |
| **Reason for Referral & Referral Refinement Check** | | | | | | | | | | | | | | | | | | | | | | | |
| **Referrals for an isolated abnormal finding of raised IOP will only be accepted following refinement with Goldmann Tonometry.**  **You must complete this section in full or your referral may be rejected.** | | | | | | | | | | | | | | | | | | | | | | | |
| **Reason for Referral** (check all that apply) | | | | | | | | | |  | **Referral Refinement Check** (Suspected OHT referrals only) | | | | | | | | | | | | |
| Limbal AC depth <25% AND symptoms OR 1+ ‘plus factors’ | | | | | | | | | |  | \* If you checked this box, please select ONE of the following:  IOP ≥32mmHg in one/both eyes with Goldmann  Tonometry on ONE or more occasions  IOP ≥24mmHg in one/both eyes with Goldmann  Tonometry on TWO or more separate occasions  Pt’s CCG has not commissioned a Level 1c scheme  Name of CCG: | | | | | | | | | | | | |
| Suspected glaucomatous optic nerve head changes | | | | | | | | | |  |  | | | | | | | | | | | | |
| Suspected glaucomatous visual field defect | | | | | | | | | |  |  | | | | | | | | | | | | |
| Suspected OHT \* (complete ‘Referral Refinement Check’ also) | | | | | | | | | |  |  | | | | | | | | | | | | |
| Referring Optometrist: | | PRINT  Name: | | | | | | | Signature: | | | | | | | | | GOC No: 01- | | | Date: | | |
| Name & Address of GP | |  | | | | | | Name & Address of Optometrist | | | | | | |  | | | | | | | | |

Version 2022b; Date: 11/07/2022