|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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 | | | | | | Hospital Number (if known) | | |
| 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? | | | | | | Yes / No / Unreliable | | Yes / No / Unreliable | | | | | | | | | IOP this visit:  Time: | | mmHg | | mmHg | |
| Visual field (enclose plot) | | | | | | Normal / Suspect / Abnormal | | Normal / Suspect / Abnormal | | | | | | | | |  | | | |
| Defect confirmed on repeat? | | | | | | Yes / Not repeated | | Yes / Not repeated | | | | | | | | | Tonometer  Used | | Goldmann  NCT model: \_\_\_\_\_\_\_\_\_\_\_\_  Perkins  iCare  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| C:D ratio / vertical disc size | | | | | | / mm | | / mm | | | | | | | | |
| Optic Disc / Neuro-retinal rim | | | | | | Normal / Suspect / Abnormal | | Normal / Suspect / Abnormal | | | | | | | | |
| Limbal AC depth | | | | | | Open >25% / Narrow <25% | | Open >25% / Narrow <25% | | | | | | | | | Previous IOP:  Date & Time: | | mmHg | | mmHg | |
| If narrow – any symptoms? | | | | | | None / brow-ache / haloes / other: | | | | | | | | | | |  | | | |
| ‘Plus’ factors? (narrow AC) | | | | | | Only eye / vulnerable / FH of AC / Rx >+6D / freq’ dilation / anticholinergic medication / remote living or working | | | | | | | | | | | | | | | | |
| 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** (tick 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 | | | | | |  | | | | | | |

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