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| Norfolk & Norwich University Hospitals NHS Foundation TrustSuspect Glaucoma Direct Referral Form |
| Email direct to NNUH: 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 | TonometerUsed | [ ]  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: | PRINTName: |  Signature: GOC No: 01- Date: |
| Name & Address of GP |  | Name & Address of Optometrist |  |

Version 2022b; Date: 11/07/2022