Gloucestershire Ophthalmology Service: YAG LASER DIRECT REFERRAL FORM

PATIENT	
First Name: Surname:	
DOB:	
Address: Postcode:	
Telephone:	

OPTOMETRIST	
Name:	
Practice:	
Address Postcode NHS.net	
Tel:	

GP
Name:
Address:

I am referring this patient for assessment for a YAG laser capsulotomy **RE** ☐ **LE** ☐

Visual Acuity: **RE** **LE**

Date of original surgery:

Adequate Fundal View ? ☐ **Yes** ☐ **No**

Current Rx	Visions	Sph	Cyl	Axis	Prism	Add	Near VA
RIGHT							
LEFT							

Ophthalmic History:

☐ Eye drops – specify:

IOPs
RE:
LE:
Time:
Instrument:

Significant Ocular Pathology which might affect outcome:

- ☐ Glaucoma
- ☐ Age Related Macular Changes
- ☐ Retinal Detachment
- ☐ Diabetic Retinopathy
- ☐ Traumatic Injury
- ☐ Amblyopia/Squint/Phoria

Other:

Optometrist's Comments:

Optometrist Signature: **Date:**

OPHTHALMOLOGY

1 Copy for Ophthalmology Provider *1 Copy for GP (for information only)* *1 Copy for Optometrist's records*