WECS(3)

Referral Form: Optometry to Ophthalmology



Principle Reason for Referral	EMERGENCY / PRIORITY / IN TURN

Pati	ent Deta	ails						Ор	tometris	st Practice (Capitals or S	Stamp)	
Title	e: Mr/Mi	ss / Mrs / N	/ls / Dr /	Other:			Sex: M / F					
Surname: Forenames:												
Address:												
					Postcode:							
DOF												
DOB:									e of exar	mination://	/	
Tel. Number(s) / E Mail Address Interpreter: Required / Not required Language										rral:/		
int	erpreter:	Required /	not rec	quired i	-anguage							
	• • • aract Ref	ferral:	Will p		ndergo catara Workin		y? Y/N Carer∫			hange? Y/N (see below) mpromised Safety F	Problem	<u> </u>
- Kig	JIII			:								
		Disc featu	ıres		IOP (mmHg)	Time	Field defect		osure	Macula feature	es 	
R							Y/N	Y	/ N			
L							Y/N	Y	/ N			
<u>Pati</u> Kno		ditions:		•	(Incl. know	n allergi	es)					
	Vision	SPHERE	CYL	AXIS	PRISM / BASE	<u>VA</u>	<u>PH</u>	ADD	NEAR VA	PREVIOUS Rx	BEST VA	DATE
R					27.32				221			
L												<u> </u>
Sign	ed			(Optome	trist) Print Na	me		Opł	th. List N	o Date	//	
										g you as required	Surgery	/H.C.
Mr/N	/lrs/Miss/Dr						of				Hos	pital.
Hos	pital Copy	/ 🗌			Opto	metrist Co	рру 🗌			GP Copy		
(for	referral p	ourposes)			(for re	ecords)			(fc	or information: do not for	ward to	HES)

Version 122015_002

Product Code: WECS3

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	GIG CYMRU NHS WALES
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_									_				
Patient Details									Optomet	rist F	Practice (Capitals or S	tamp)	
Title: Mr / Miss / Mrs / Ms / Dr / Other: Sex: M / F													
Surname: Forenames:													
Address:													
Postcode:													
DO	B:/	/		NHS / I	Hosp No. (if k	nown)							
Tel. Number(s) / E Mail Address									Date of ex	kamin	ation:/	/	
In	terpreter:	Required	/ Not red	quired L	anguage]	Date of re	ferra	l:/	/	
Fin	dings an	d Provisio	nal Dia	gnosis:									
	•												
	•												
	•												
	•												
	•												
Cat	aract Re	ferral:	Will p	atient ur	ndergo catara	act surgery	y? Y/N		Refractive	e cha	nge? Y/N (see below)		
Ri	ght 📗 L	eft 🗌	Drive	er	Workin	g 🗌	Carer		Lifestyle (Comp	romised Safety P	roblem	
		Disc feat	ures		IOP (mmHg)	Time	Field		Enclosure		Macula feature	s	
R							defect Y/N		Y/N				
L							Y/N		Y / N				
Rel	evant Fa	mily Ocul	lar Histo	orv:									
		-		-	(In al. lan acce	n allauni	1						
			tn intor	mation	(Incl. know	<u>n allergie</u>	<u>es)</u>						
Kn	own con	ditions:											
Kn	own med	lication:											
	Vision	SPHERE	CYL	AXIS	PRISM / BASE	<u>VA</u>	<u>PH</u>	AD	D NE		PREVIOUS Rx	BEST VA	DATE
R					<i>B7</i> (32					<u>.</u>		"	
L.													
L													
<u> </u>				(0.1							5 .	, ,	
Sigr	ned			(Optome	trist) Print Na				Jphth. Lis	t No	Date	.//	
For	the attenti	on of Dr					of					Surgery	ı/H.C.
<u>I AI</u>	M REFERR	NG THIS P	ATIENT	ГО ОРНТ	THALMOLOG'	Y AS INDI	CATED BEL	OW a	and inforn	ning y	ou as required		
Mr/l	Mrs/Miss/Di						of					Hos	pital.
Hos	pital Cop	<u> </u>			Opto	metrist Co	рру				GP Copy		
(for	(for referral purposes) (for records) (for information: <u>do not forward to HES</u>)												

Version 122015_002

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WECS	(3)		R	eferra	l Form:	Optor	netry t	o Oph	thalm	ology		2	GIC
Princip	ole Rea	ason for	Referra	al	•••••	••••	E	MERGEN	CY / PRI	ORITY / IN T	URN 🐧	37	CYMRI NHS WALE
Patier	nt Deta	ails						Opt	ometrist	Practice (Ca	pitals or S	tamp))
Title:	Mr / Mi	ss / Mrs / N	/ls / Dr /	Other:			Sex: M / F						
Surnar	me:												
Address:													
					. Postcode	:							
DOB: .	/.	/		NHS / H	osp No. (if	known)							
Tel. Nu	umber(s	s) / E Mail .	Address					Date	e of exam	ination:	/	/	
Inter	preter:	Required /	/ Not red	quired La	nguage			Date	e of refer	al:	/	/	
Catara Right	act Ref	ferral:	Will p		dergo catar Workir		y? Y/N Carer[ange? Y/N(s	see below) Safety P		n 🔲
		Disc featu	ıres	I	OP (mmHg)	Time	Field	Enclo	sure	Ma	cula feature	s	
R							defect Y/N	Y /	' N				
L							Y/N	Υ/					
<u>Patier</u> Know	nt Gen	mily Ocul eral Heal ditions: lication:		•	Incl. know	vn allergi	es)						
	Vision	SPHERE	CYL	AXIS	PRISM / BASE	<u>VA</u>	<u>PH</u>	ADD	NEAR VA	PREVIO	US Rx	BEST VA	DATE

(for records)

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