GOS18 Ophthalmic Referral/Information for GP

Please use black ink to fill in this form

Date of sight test .... **Date of referral (if different)** ....

Optometrist/OMP Name and Practice Address

Post Code: ____________ Tel: ______________________________

NHS mail: ____

GP Name and Practice Address

Patient details

Title Gender M / F

Surname

Forenames

Address

Post Code: ____________

Telephone: ______________________________

Date of Birth ______________________________

NHS Number (if known) ______________________

GP Action required: (Also see "additional information" below)

- ☐ This letter is for INFORMATION ONLY
- ☐ Patient asked to telephone/visit GP
- ☐ Patient sent to Eye Casualty
- ☐ Advise Referral to Eye Dept **(URGENT)**
- ☐ Advise Referral to Eye Dept (Routine)

CHILDREN: Clinic Type suggested for referral to HES (tick most urgent one)

- ☐ Strabismus and Amblyopia
- ☐ Paediatric non-strabismus
- ☐ Orthoptic (only)

ADULTS (16 or older): Clinic Type suggested (tick most urgent one)

- ☐ Cataract
- ☐ Cornea
- ☐ Diabetic Medical Retina
- ☐ External Eye Disease
- ☐ Glaucoma
- ☐ Laser (YAG capsulotomy)
- ☐ Low Vision
- ☐ Oculoplastics / Orbits / Lacrimal
- ☐ Other Medical Retina (incl ARMD)
- ☐ Squint / Ocular motility
- ☐ Vitreoretinal
- ☐ Not Otherwise Specified

CLINICAL TERM(S):
Enter relevant keyword(s) (these are to help the GP to find correct HES service)

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	Sph	Cyl	Axis	Prism	Base	VA	Pinhole	Add	Near Vision	Previous corrected VA on (date)
Right										
Left										

	Right eye	**Left eye**	
Visual fields	Normal/enclosed (if abnormal)	Normal/enclosed (if abnormal)	
Optic nerve heads	C:D	C:D	
Intraocular pressure Time______________	mm Hg	mm Hg	Applanation/non contact/ Other______________

Additional information Cycloplegic refraction ☐ Dilated fundus examination ☐

GOS 18 Part One – This part must accompany any referral made to an Eye Department

STATEMENT: The reason for this referral has been explained to the patient or guardian who agrees to it. The patient or guardian also consents to information being exchanged between the Hospital Eye Service, their General Medical Practitioner, and optometrist or ophthalmic medical practitioner (delete any not consented to).

If appropriate, Guardian's name and address____

Signed (optometrist/OMP)______________________________________GOC/GMC No______________________