# 

**Hartlepool**

**Middlebrough**

**Redcar & Cleveland**

**Stockton-on-Tees**

# IOP Refinement Referral Form

Please complete only for patients with IOP > 21mmHg, with no other signs of glaucoma.

***Please forward 2 copies to the GP - 1 for GP***

***1 for Hospital Consultant***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient’s Details | |  | Optometrist / Practice | | |
| First name: |  |  | Optometrist: | |  |
| Last name: |  |  | OPL number: | |  |
| DOB: |  |  | Practice: | |  |
| NHS number (if known): |  |  |
| Address: |  |  |
|  | Phone: | |  |
|  |  | | |
|  | Patient’s GP | | |
| Phone: |  |  | GP name: |  | |
| Mobile: |  |  | Practice: |  | |
| Email: |  |  |

# Tonometry

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Initial Tonometry Reading: | | Right: | Left: | | Time: | Date: | |
| 1st Applanation Tonometry Reading: | | Right: | Left: | | Time: | Date: | |
| 2nd Applanation Tonometry Reading: | | Right: | Left: | | Time: | Date: | |
| 1st Applanation  IOP > 31mmHg  ***Urgent referral*** |  | 2nd Applanation  IOP 22 – 30mmHg  IOP Difference ≥5mmHg  ***Routine referral*** |  | 2nd Applanation  Age ≥ 65 years IOP 22 - 24 mmHg  Age ≥ 80 Years IOP 22 – 25 mmHg  ***Non Urgent referral for OHT monitoring*** | | |  |
|  | | | | | | | |

# Glaucoma Risk Factors

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *C: D Ratio* | **R** |  | **L** |  | ***Comment*** |
| Family History | Yes: |  | No: |  | Details |
| Other Risk Factors | Yes: |  | No: |  | Details |

# Visual Fields: Full Fields/Non-Glaucomatous Field Defect (Delete as appropriate) - Copy Enclosed

**Prescription from Current Sight Test**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Vision | Sph | Cyl | Axis | Prism | VA | Add | Near VA | Previous VA | |
| R |  |  |  |  |  |  |  |  |  | Date: |
| L |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| Additional comments: |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Signature: |  | *Optometrist*  *Signature:* | Date: |  |

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