Appendix 1

NHS

Improving Health Together

South Tees Clinical Commissioning Group

South Tees CCG - Low Vision Referral Form

Information for the Low Vision Practitioner

Patient eligibility	• Best corrected VA6/18 or N9 with a +4.00 add • Patients registered with a South Tees CCG GP

Patient surname (Mr, Mrs, Miss, Ms, Dr): ____________________

Other name(s): ____________________

Address: ____________________

Phone Number: ____________________

Date of birth: ____________________ NHS No: ____________________

Date of last sight test: ____________________

GOS sight test required: Yes ☐ No ☐

Please can you advise patients if they need a sight test to contact their usual Optometrist before making an appointment?

	SPH	CYL	AXIS	VA	ADD	NEAR VA
R						
L						

Main causes of visual impairment:

Is the patient currently under HES: Yes ☐ No ☐

Is this patient being referred to the hospital eye service? Yes ☐ No ☐

Patient's main visual problems (e.g. reading, watching TV etc.):

Name and address of referring optometrist/ophthalmologist:

Name:
Address:

I declare that the information given on this document is true and complete to the best of my knowledge and I consent to the disclosure of relevant information on this form for the purposes of fraud prevention, detection and investigation.

Signature: ____________________ Date: ____________________

The patient then needs to contact a Low Vision Practitioner of their choice to arrange an appointment for low vision assessment.

Form to be photocopied - 1 for patient – 1 for GP – 1 for your practice records