

# ACES Referral Form

<b>Name of Patient:</b>		<b>Patient Date of Birth:</b>	
<b>Patient Address:</b>			
<b>Patient Home Phone Number:</b>		<b>Patient Mobile Phone Number:</b>	
<b>Patient Email Address:</b>		<b>Patient NHS Number</b>	

<b>GP Name:</b>			
<b>GP Practice Address:</b>			
<b>GP Practice Email Address:</b>			

<b>Optometrist Name:</b>		<b>Optometrist Referral?</b>	<b>Yes</b>	<b>No</b>
<b>Optometrist Address:</b>				
<b>Optometrist Phone Number:</b>		<b>Optometry Practice Email Address:</b>		

Referral For (please tick):

	Cataract	PCO (YAG)	Glaucoma	Oculoplastics / Lacrimal	General (other)
RE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Examination Date:

	UAVA	Sph	Cyl	Axis	Prism	BCVA	Add	Near VA	Previous Corrected VA:	Date of Previous Corrected VA:
RE										
LE										

Optic Disc	RE	LE	IOPs		RE	LE
Appearance			NCT or Applanation			
C:D			Time			

Visual fields	RE	LE
If abnormal please attach copy of visual fields		

Additional information required for eye with cataract and better than 6/12 BCVA:

Symptoms / Conditions	Yes	No	Symptoms / Conditions	Yes	No
Glare, Haloes or Starbursts			Anisometropia		
Employment Problems			Co-existing Eye Condition(s)		
Reading Difficulty			Refractive Shift due to Cataract		

Additional Information:

Signed:

GOC / GMC Number:

Date:

Return this form to [capccg.acesreferrals@nhs.net](mailto:capccg.acesreferrals@nhs.net) or