

ACES Referral Form



Name of Patient:		Patient Date of Birth:	
Patient Address:			
Patient Home Phone Number:		Patient Mobile Phone Number:	
Patient Email Address:		Patient NHS Number	

GP Name:			
GP Practice Address:			
GP Practice Email Address:			

Optometrist Name:		Optometrist Referral?	Yes	No
Optometrist Address:				
Optometrist Phone Number:		Optometry Practice Email Address:		

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 acesreferrals.birmingham@nhs.net