ACES Referral Form

ACES

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	◯	◯	◯	◯	◯
LE	◯	◯	◯	◯	◯

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
Appearance		
C:D		

IOPs	RE	LE
NCT ◯ or Applanation ◯		
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
Glare, Haloes or Starbursts	◯	◯
Employment Problems	◯	◯
Reading Difficulty	◯	◯

Symptoms / Conditions	Yes	No
Anisometropia	◯	◯
Co-existing Eye Condition(s)	◯	◯
Refractive Shift due to Cataract	◯	◯

Additional Information:

Signed:		GOC / GMC Number:		Date:	

Return this form to cpicb.acesreferrals@nhs.net