GOS Specialist Supplementary Referral Form & Back to Referrer Letter

This document is to be used to make a referral under the GOS Specialist Supplementary Service, and then also to provide feedback on the referral to the referring practitioner. Feedback can be provided either during, or at the end of, the episode of care as determined by the IP optometrist responsible for the patient's care.

Referral Form

This template is for use to refer the patient to an Independent Prescribing (IP) Optometrist for Advanced Anterior Eye Management. It is imperative that a phone call is made to the optometrist in advance of the referral to ensure that there is capacity for the patient to be seen in a timely fashion.
Recieving IP Optometrist Search can be found at www.nhsinform.scot/scotlands-service-directory/opticians

Patient Demographics

Title

First Name(s)

Surname

CHI Number

Date of Birth

Sex ○ Male ○ Female

Priority **Urgent**

Address

Postcode

Telephone Number

Optometry Referral Details

Date of Referral

Reason for Referral

- ☐ Anterior Uveitis
- ☐ Anterior & Posterior Blepharitis
- ☐ Episcleritis
- ☐ Herpes Zoster Ophthalmicus (HZO)
- ☐ Herpes Simplex Keratitis
- ☐ Ocular Rosacea
- ☐ Infective Conjunctivitis
- ☐ Marginal Keratitis
- ☐ Ocular Allergy
- ☐ Corneal Foreign Body

General Information

Additional Comments including History

Ocular Information

Ocular Examination - External / Internal

Ocular Comment Right

Ocular Comment Left

Tonometry

Tonometry Right

Tonometry Left

RAPD

Time

Time-hrs

Time-mins

Applanation

Fields Attached

Images Attached

Visual Acuity

Right Eye

R VA Today

R PH VA Today

Left Eye

L VA Today

L PH VA Today

Previous Examination (if known)

R VA at previous examination

Date of previous VA

Previous Examination (if known)

L VA at previous examination

Patient GP Details

Name

Practice Code

Practice Name

Address

Postcode

Referrer

Forename

Surname

GOC Code

Telephone Number

Practice Name

Address

Postcode

Referral To

Specialty **Optometry**

Protocol **GOS Specialist Supplementary**

Telephone Number

Optometrist Practice Name

Address

Postcode

Additional Support Needs Information

Hearing impairment/deaf ☐

Visual impairment/blind ☐

Deafblind ☐

Language requirement ☐

Speech impairment ☐

Learning disability ☐

Mobility impairment: Poor mobility ☐

Very poor mobility ☐

Immobile ☐

Housebound ☐

Cognitive: Dementia ☐

Aspergers/Autism ☐

Other additional need (please specify)

Detailed Requirements

Communication

Requires written information ☐

Requires information by e-mail ☐

Requires information in large font ☐

Requires audio information ☐

Requires information in Easyread ☐

Requires information by text relay/text phone ☐

Requires hearing loop ☐

Requires verbal information / information by phone ☐

Requires information in Braille ☐

Requires other communication device (please specify below)

Additional Support Needs Information

Requires BSL interpreter ☐

Requires Contact Scotland/face-time BSL interpreting ☐

Requires a touch hand communicator ☐

*Requires a language interpreter (telephone) ☐

*Requires information translated (please specify language) ☐

Requires a lip speaker (+/- sign support) ☐

Requires a deafblind/ guide communicator ☐

Requires Makaton interpreter ☐

*Requires a language interpreter (in person) ☐

*Language

(To ensure Medical Records have the appropriate information to book an interpreter please select "Requires a language interpreter (in person)" and also enter details of the language required.)

Completed forms must be emailed from an NHS email address to an NHS email address only

END OF REFERRAL FORM

Back To Referrer Letter

This section of the form is to be used by the IP optometrist responsible for the patient's care to provide feedback to the referrer.

Patient Demographics

Title

First Name(s)

Surname

CHI Number

Date of Birth

Address

Post Code

Telephone Number

Email Address

Date of Attendance

Patient attended on:

Conditions Treated

- ☐ No Conditions treated
- ☐ Anterior Uveitis
- ☐ Anterior & Posterior Blepharitis
- ☐ Episcleritis
- ☐ Herpes Zoster Ophthalmicus
- ☐ Herpes Simplex Keratitis
- ☐ Ocular Rosacea Infective
- ☐ Conjunctivitis
- ☐ Other
- ☐ Marginal Keratitis
- ☐ Ocular Allergy
- ☐ Corneal Foreign Body

Treatment Provided

- ☐ Topical antibiotics
- ☐ Topical antihistamine eye drops
- ☐ Topical ocular lubricant eyedrops
- ☐ Topical cycloplegics
- ☐ Oral antibiotics
- ☐ Oral NSAIDs
- ☐ Nasal antihistamine spray
- ☐ Topical antiviral drugs
- ☐ Topical NSAIDs
- ☐ Topical ocular lubricant
- ☐ Ointment Pilocarpine Oral
- ☐ antivirals
- ☐ Oral corticosteroids
- ☐ Nasal corticosteroid spray
- ☐ Topical corticosteroid eye drops
- ☐ Topical corticosteroid skin cream
- ☐ Topical glaucoma eye drops
- ☐ Topical immunosuppressant agents
- ☐ Oral antihistamines
- ☐ Oral CAIs
- ☐ Skin emollients

Treatment Details / Other Treatments

Outcome

- ☐ Condition managed to resolution
- ☐ Patient referred to HES
- ☐ Treatment initiated - review arranged
- ☐ Patient referred to GP
- ☐ Treatment altered - review arranged
- ☐ Patient returned to referrer

Additional Comments:

Sent By

IP Surname		IP GOC Number	
IP Forename		Practice Name	
Specialty	**Optometry**	Address	
Protocol	**GOS Specialist Supplementary**		
Telephone Number		Postcode	

Send To

Referrer Forename		Practice Name	
Referrer Surname		Address	
		Postcode	

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