Email your referral to DRSS:
d-ccg.drss-admin@nhs.net

NHS England

Emergency: ☐	Wet AMD: ☐	Urgent: ☐	Routine: ☐

Patients Details:

Date of referral:	Patients Address:
Title:	
Forenames:	
Surname:	
Date of Birth:	Postcode:
Email Address:	NHS Number (*if known*):
Home Tel:	Work/Mobile Tel:
Referring Ophthalmic Practitioner's Details	**Patient's Current GP Details**
Practitioner's Name:	GP's Name:
Practice Address:	GP Practice Address:
Practice Tel:	

Primary Reason for referral:

☐ AMD (Wet)	☐ Low Vision
☐ Cataract and patient wants surgery	☐ Neuro-Ophthalmology
☐ Cornea	☐ Oculoplastics / Orbital / Lacrimal
☐ Diabetic Medical Retina	☐ Orthoptics
☐ External Eye Disease	☐ Other Medical Retina
☐ Glaucoma	☐ Paediatrics
☐ Raised IOP only	☐ Squint, Ocular Motility
☐ Laser (YAG Capsulotomy)	☐ Vitreo-retinal
	☐ Not otherwise specified (Includes suspected cancer)

Eye	Vision/ VA	Sph	Cyl	Axis	Prism	VA	PH	Add	Near VA	Previous VA + Date:
Right										
Left										

IOP	Time of IOP:	Visual Fields: (Tick as applicable)	Disc Appearance:
Right	mmHg	Normal ☐ Defective ☐ Unreliable ☐ Not Possible ☐	
Left	mmHg	Normal ☐ Defective ☐ Unreliable ☐ Not Possible ☐	

Type of Tonometer:		Visual Fields Instrument:	

Findings and Explanation:

Cycloplegic Refraction: ☐	Dilated Fundus Examination: ☐	DRSS to initiate contact with patient: ☐

Does the patient have a disability? ☐ If yes please specify:

STATEMENT: The reason for this referral has been explained to the patient or guardian who agrees to it. The patient or guardian also consents to information being exchanged between the Hospital Eye Service, their General Medical Practitioner and Optometrist or Ophthalmic Medical Practitioner (Please tick if patient does not consent:☐).

Practitioners Name:_____ Date:_____