# *Norfolk & Norwich University Hospitals NHS Foundation Trust*
# *Suspect Glaucoma Direct Referral Form*

**Email direct to NNUH: OPServicesPostTeam@nnuh.nhs.uk (from an '@nhs.net' address only)**

## Patient Details

| Title (Dr Mr Mrs Miss Ms) | Surname | Other Names |
|---|---|---|
| | | |

| Address | DoB: |
|---|---|
| | Phone: |
| Post Code | Hosp No: |

## Details of Current Sight Test

Date:

| | Vision | Sph | Cyl | Axis | Prism | Add | VA | Near VA |
|---|---|---|---|---|---|---|---|---|
| Right Eye | | | | | | | | |
| Left Eye | | | | | | | | |

## Clinical Findings: Reasons for Suspecting Glaucoma

| ***Please circle or complete*** | **Right Eye** | **Left Eye** | | **Right Eye** | **Left Eye** |
|---|---|---|---|---|---|
| Visual fields performed? | | | IOP this visit: | mmHg | mmHg |
| Visual field (enclose plot) | | | Time: | | |
| Defect confirmed on repeat? | | | Tonometer Used | ☐ Goldmann | |
| C:D ratio / vertical disc size | / mm | / mm | | ☐ NCT model: _____ | |
| Optic Disc / Neuro-retinal rim | | | | ☐ Perkins ☐ iCare | |
| | | | | ☐ Other: _____ | |
| Van Herrick AC grading | | | Previous IOP: | mmHg | mmHg |
| If narrow – any symptoms? | | | Date & Time: | | |

| Other signs/risk factors (e.g. +ve FH, disc haem, PXF, PDS) | |
|---|---|
| Any other comments: | |

## Reason for Referral & Referral Refinement Check

**Referrals for an isolated abnormal finding of raised IOP will only be accepted following refinement with Goldmann Tonometry. You must complete this section in full or your referral may be rejected.**

| **Reason for Referral** (check all that apply) | ☐ | **Referral Refinement Check** (Suspected OHT referrals only) |
|---|---|---|
| Suspected narrow anterior chamber angles | ☐ | * If you checked this box, please select ONE of the following: |
| Suspected glaucomatous optic nerve head changes | ☐ | ☐ IOP ≥32mmHg in one/both eyes with Goldmann Tonometry on ONE or more occasions |
| Suspected glaucomatous visual field defect | ☐ | ☐ IOP ≥24mmHg in one/both eyes with Goldmann Tonometry on TWO or more separate occasions |
| Suspected OHT * (complete 'Referral Refinement Check' also) | ☐ | ☐ Pt's CCG has not commissioned a Level 1c scheme<br>Name of CCG: |

| Referring Optometrist: | PRINT<br>Name: | Signature: | GOC No: 01- | Date: |
|---|---|---|---|---|

| | | | |
|---|---|---|---|
| Name & Address of GP | | Name & Address of Optometrist | |