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)	Other Names
Address	DoB:
	Phone:
	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	**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		☐ NCT model: _____	
Optic Disc / Neuro-retinal rim			☐ Perkins ☐ iCare	
			☐ Other: _____	
Limbal AC depth		Previous IOP:	mmHg	mmHg
If narrow, any symptoms?				
If narrow, any "plus" factors?				
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)
Limbal AC depth <25% AND symptoms OR 1+ 'plus factors'	* 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 Name of CCG:

Referring Optometrist:	PRINT Name: Signature: GOC No: 01- Date:

Name & Address of GP		Name & Address of Optometrist	