CRVO & BRVO Referral Form

Patient Details

Name:

Address:

Contact Tel Nos:

Date:

DoB:

Hospital No: *(if known)*

GP:

GP Surgery:

Optometrist Details *(please stamp clearly or print)*

Practice:

Address:

Tel:

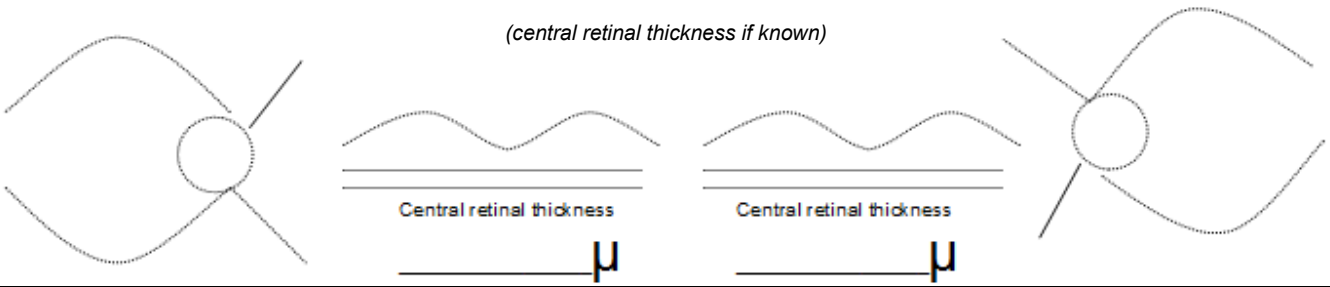
Optometrist:

Signature: . . . . . .

Affected Eye: **Right** ☐ **Left** ☐

	Right	Left
Duration of visual loss	months	months
Best corrected visual acuity:		
Past ocular history (if relevant):		

(central retinal thickness if known)



Findings:

	Right	Left
Type of RVO	None	None
Other ocular abnormality		
Intraocular Pressures	mmHg	mmHg
Any other comments:		

Spectacle Prescription and corrected VA

	Sph	Cyl	Axis	Prism	VA	Add	NVA
R							
L							

You may wish to phone to confirm safe receipt of a fax. These referrals are not normally urgent. If there are any unusual features (such as the patient is unwell, optic nerve head swelling is present or the patient is of a young age, then please ring the urgent clinic to discuss the case.

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(GP Information Letter)

This patient has a Retinal Vein Occlusion

Patient Details	**Date:**
Name:	DoB:
Address:	Hospital No: *(if known)*
Contact Tel Nos:	GP:
	GP Surgery:

The above-named patient has been advised to contact your practice urgently to arrange a consultation with the practice nurse / health care assistant for the following checks to aid in identifying an underlying cause of the retinal vein occlusion.

Requested blood tests (if not been carried out within the last 6 weeks):

- **Blood pressure measurement**
- **eGFR**
- **Serum Glucose estimation**
- **Blood Lipid check**

The patient has been referred directly via the Retinal Vein Occlusion pathway, no further referral to ophthalmology is required.

Optometrist Details *(please stamp clearly or print)*	
Practice:	Optometrist:
Address:	Signature: . . . . .
Tel:	