

CRVO & BRVO Referral Form

Patient Details

Date:

Name:

DoB:

Address:

Hospital No: (if known)

Contact Tel Nos:

GP:

GP Surgery:

Optometrist Details (please stamp clearly or print)

Practice:

Optometrist:

Address:

Signature:

Tel:

Affected Eye:

Right ☐

Left ☐

Duration of visual loss

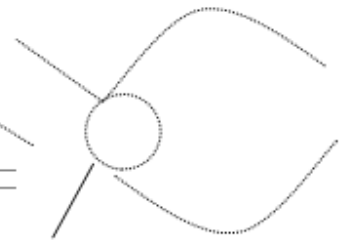
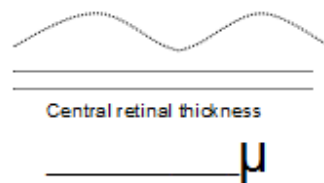
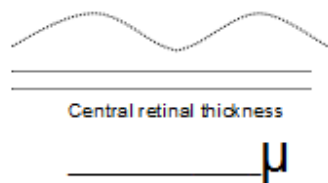
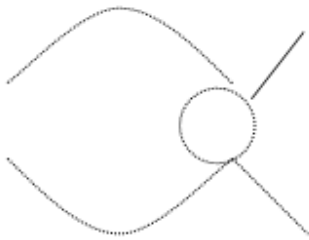
months

months

Best corrected visual acuity:

Past ocular history (if relevant):

(central retinal thickness if known)



Findings:

Right

Left

Type of RVO

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.

CRVO & BRVO Referral Form

(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:	