**STROKE Orthoptic Referral**

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| **Name: Sheila**  |  | **Current ward:** |  |
| **DOB:** |  | **Consultant:** |  |
| **HEY:** |  | **Referring clinician:** |  |
| **NHS:** |  | **Designation:** |  |

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| **Details of condition:**  |
| **Date of onset:**  | **Clinical diagnosis:** |
| **MRI / CT date and report:** |

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| **Ocular symptoms** (please mark with a ✓) | **Ocular signs** (please mark with a ✓) |
| Double vision |[ ]  Reading difficulties |[ ]  Squint / turn in eyes |[ ]  Ptosis (lid droop) |[ ]
| Blurred vision  |[ ]  Visual field loss |[ ]  Defective eye movements |[ ]  Abnormal pupils |[ ]
| Nystagmus (wobbling eyes) |[ ]  Closing one eye |[ ]  Misjudging distance |[ ]  Family concerns |[ ]

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| **Ocular History** | **Glasses** | **Y/N** |
|  | Does the patient usually wear glasses? |  |
| Does the patient need glasses? |  |
| Does the patient have their glasses? |  |

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| **General Information Y/N** |
| Can the patient come to the eye clinic (walking / in wheelchair)? YesYesindependentlyYes mobile |  |
| Does the patient require a ward visit? |  |
| Is the patient ready for immediate assessment? |  |
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| **Please e-mail referral for the attention of Orthoptic Department to both:****a.lindstrom@nhs.net** **and** **m.maqsud@nhs.net****or fax to: 01482 816749****or post to: A Lindstrom, Orthoptic Department, Eye Hospital, Fountain Street, HRI** |