**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**](mailto:a.lindstrom@nhs.net) **and** [**m.maqsud@nhs.net**](mailto:m.maqsud@nhs.net)  **or fax to: 01482 816749**  **or post to: A Lindstrom, Orthoptic Department, Eye Hospital, Fountain Street, HRI** |