**Visual Fields Referral**

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| Patient details | | Referrer details | |
| **Name:** |  | **Department:** |  |
| **DOB:** |  | **Consultant:** |  |
| **HEY:** |  | **Referring clinician:** |  |
| **NHS:** |  | **Designation:** |  |
| **Contact No:** |  | **Date of request:** |  |
| **Any upcoming outpatient appointment Dates:** | | | |

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| **Clinical diagnosis:** | | |
| **What defect are you looking for?** |  | |
| **Time frame visual field required:** | |  |

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| Is patient able to sit on a chair unaided |  | Is the patient to concentrate for 5 minutes |  |
| Can the patient come to the eye clinic (walking / in wheelchair)? |  | Is the patient able to follow simple instructions |  |

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| **Any additional comments:** |
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| **Please e-mail referral for the attention of Orthoptic Department:**  [**orthoptichey@nhs.net**](mailto:orthoptichey@nhs.net) |