Date



# Birmingham and Midland Eye Centre
# Vitreo-Retinal Referral Form

Referring Hospital:

NHS number:

Patient Name:

Patient Contact Number:

Date of Birth:

Address:

**Reason for referral:**

**If referring for dropped nucleus, please email biometry results. If not, the referral will be rejected.**

**Presenting symptoms:**

Floaters

Field defect

Photopsia

Asymptomatic

**Duration of symptoms:**

**Eye Affected:**

**Other history & details**

Prior intra-ocular surgery

Post ophthalmic history

Trauma

Anticoagulants

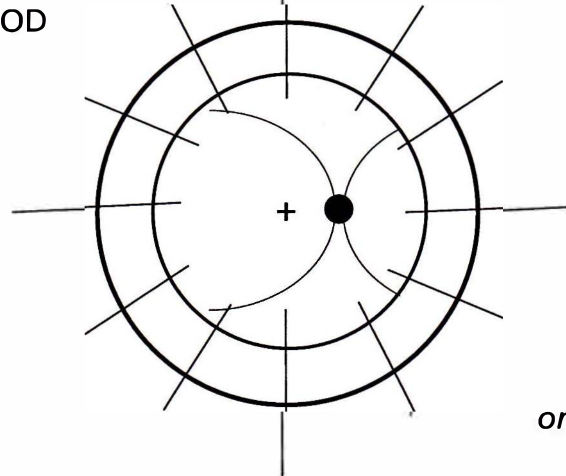
Refractive error

Systemic

**Use Adobe Acrobat software to draw the detachment and breaks choose Tools > Comment > Draw > Close Comment Section to continue with other sections**

**Examination**

OD



*RAPD*

*BC VA*

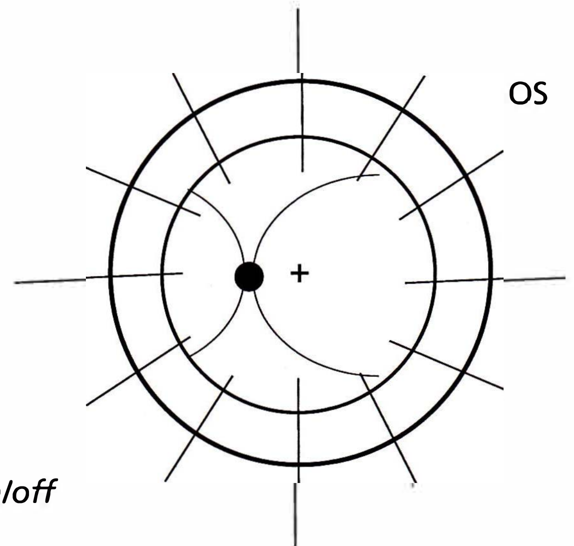
*IOP*

*Lens Status*

*Vit haem*

*PVD*

*on/off* *Macula* *on/off*



OS

Referring Doctor

Contact Number of the Referring Doctor

Name of VR Fellow / Consultant Informed:

Inform the VR fellow by PHONE then EMAIL this form to vrbmec@nhs.net. Any incomplete forms will be rejected.

Where EVERYONE Matters