Clinical telephone/video review

THE COLLEGE OF OPTOMETRISTS

Patient name:		Patient identifier:	
Contact details:		Date of birth:	
Relevant OH:		Date of last sight test:	

Reason for contacting the practice

Existing spectacle prescription (if relevant)		
Right:		Previous VA
Left:		Previous VA

Telephone/ video consultation (delete as appropriate)

History and symptoms	
Patient self-estimated VA (Same/ little worse/ much worse than previous)	Right Left

Have you experienced any of the following?	N/R/L
Eye pain:	
Photophobia:	
Haloes around lights:	
Recent trauma:	
Distortion in vision:	
Recent onset floaters:	
Red eye	
Sudden change in VA:	
GH/Medications:	

Recommendations (tick)

Sight/life threatening?: **Refer to eye casualty**		Minor eye condition: **Advise to self-manage**	
Potentially sight/life threatening?: **Book urgent optom review**		Non urgent condition: **Book appt in 6/12**	

Advice given:	
Signature: GOC:	Date: