

# Clinical telephone/video review

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	Have you experienced any of the following? N/R/L	
	Eye pain:	
	Photophobia:	
	Haloed around lights:	
	Recent trauma:	
	Distortion in vision:	
	Recent onset floaters:	
	Red eye	
	Sudden change in VA:	
	GH/Medications:	
Patient self-estimated VA (Same/ little worse/ much worse than previous)	Right	Left

## Recommendations (tick)

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

Advice given:

Signature: GOC:	Date:
--------------------	-------