Date

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Birmingham and Midland Eye Centre
Vitreo-Retinal Referral Form

Referring Hospital:

Patient NBM from:

Patient Name:

Contact numbers:

Date of Birth:

Address:

Presenting symptoms & duration:

Floaters

Field defect

Photopsia

Asymptomatic

Other history & details

Prior intra-ocular surgery

Myopia

Trauma

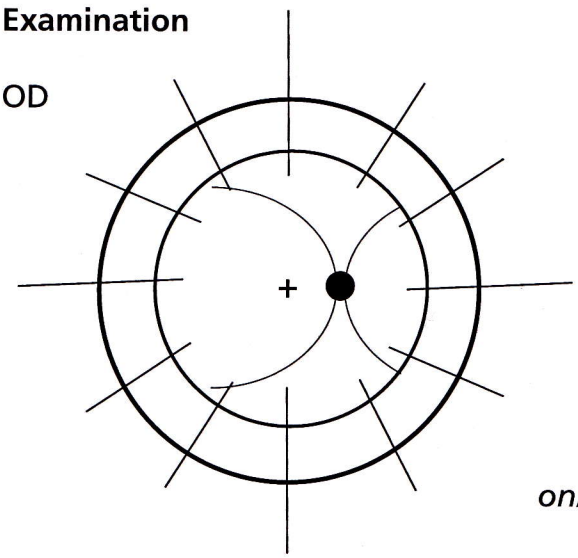
Family History

Refractive error

Systemic

Examination

OD



RAPD

BC VA

IOP

Lens Status

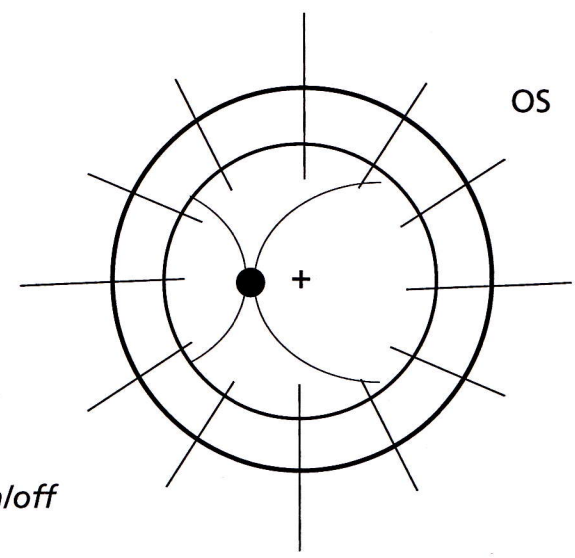
Vit haem

PVD

Tobacco dust

on/off *Macula* *on/off*

OS



Referring Doctor

Contact Number

Referring Consultant

Consultant informed? Y / N

Please complete this form and fax to: 0121 507 4068

Where EVERYONE Matters