Eye Health Examination Wales Appointment Priority Form

Archwiliadau Iechyd Llygaid Cymru
Eye Health Examination Wales

Patient Name	DOB	Telephone No.	Date

Please give a brief description of the problem and relevant eye history (e.g. good vision in 1 eye only)

Who referred the patient

Self-referred	GP referral	Pharmacy	Optom	Details:

Duration of symptoms

1-2-3 days	Less than 1 week	Less than 1 month	Over 1 month

Which eye is affected

Right eye only	Left eye only	Both eyes

How much pain is there

None	Mild	Moderate	Severe

Is the vision affected

No	Blurred	Patch / Curtain	Distortion	Total loss

Is there any discharge			Is there red eye
None	Watery discharge	Gunky discharge	yes / no

Do any of the following apply

Floaters	Flashes	Sensitive to light	Double vision	Contact lens wearer	Previous occurrence

Last examination date	Patient of this practice yes / no	Where is the patient home / in practice / with GP

Recommended urgency advice (Discuss with optometrist if necessary)

Now	Today	Next day	Routine

Plan of action

Appt. this practice	Appt. other practice	Advise go to GP	Advise go to hospital

Please give this advice to the patient

Not to drive to appointment	Not to wear contact lenses	To bring a list of medications	To bring any relevant paperwork

Optical assistant name	Optometrist name