PEARS Referral

North Kirklees Clinical Commissioning Group
Greater Huddersfield Clinical Commissioning Group
Calderdale Clinical Commissioning Group

Patient's Details	Optometrist / Practice
First Name	Optometrist:
Last Name	OPL number:
Address: Tel:	Practice Address: Phone:
Patient's signed authorisation for audit release:	

Patient's dob:		**Practice Patient Ref No:**	

Patient's GP
GP name:
Practice

Date referred to Optometrist:	Date first seen:	Further dates seen :	
Referred by: GP ☐	Patient ☐	Optometrist ☐	Other ☐ Please state

Date / Time of Onset	

Diagnosis (Please tick)

Eyelid Lumps & Bumps		Tear Dysfunction		Lid & Lash Problems		Conjunctivia	
Cornea		Anterior Uveitis		Macular Degeneration		Maculopathy	
Flashes/Floaters		Retinal Lesions		Field Defects		Systemic disease affecting eye	

Other diagnosis and comments

CLINICAL OUTCOME: (please fully complete by ticking all boxes below as appropriate)

Dist. V/A	**Right:**	**Action Taken:**				
	Left:	Treatment **completed** under **PEARS** (no further action needed) *Patient Discharged*		**Patient Referred to:** (tick all appropriate box and date referred)		
				GP		
Dilated?	**No**	*Epilated*		Community Eye Services		
	Yes	*Foreign body removed*		Hospital Eye Services (HES)		
		Lubricants		Other (specify):		
Tonometry	**Right:**	*Lid hygiene*		**EMERGENCY (within 24 hours)**		
	Left:	*Prescription requested from GP (specify)* ----------		**URGENT (within 48 hours)**		
Tonometer used				**ROUTINE**		
		Follow up (specify interval)		Date referred:		

Optometrist's Signature:	**Date:**