

HEAD & NECK SERVICES EYE CARE SERVICES (OOO)

Ophthalmology, Orthoptics, Optometry - Electronic Referral Portal

Step by step referrals

1. Load up portal via link <https://ophthalmology.cht.nhs.uk/testing/>
2. Login using username and password – sent to you in email

Account Login

For Trust staff members login details will be your computer login credentials. For external referrers you will login using your email address and set password. If these do not work then you may not have an account for this system.

Username (e.g. Firstname.Lastname or username@example.com) *

Password *

Remember Me

Syst

For Trust additional access to address E

3. Click on the 'create a referral' section – access to home page with portal guidance

Referral Hub
Use the buttons below to access and create referral requests.

Portal Stats Open Emergency Referrals: 4 Open Routine Referrals: 3	Create a Referral View portal guidance and referral forms.	My Referrals View all of the referrals you have submitted.
Emergency Referrals View referrals from the emergency forms.	Routine Referrals View referrals from the routine forms.	Appointments List Accepted referrals that have been triaged.
Filter Referrals Filter referrals by date, source, reason, and type, urgency.		

4. Click on 'create new emergency referral' for all emergency referrals
Click on 'create new cancer referral' for all cancer suspect referrals
Click on 'create new Wet AMD referral' for all suspect Wet AMD referrals
Click on 'create new routine referral' for all routine referrals

Emergency Referral Portal Guidance

This portal is monitored Mon – Fri between 08:30 – 16:00.

Monday - Friday Referrals received after 16:00 will not be reviewed until the next working day.

Saturday - Referrals received after 13:00 will not be reviewed until Monday.

Sunday – Referrals received will not be reviewed until Monday.

Monday – Friday

Before 16:00 – please refer via this portal.

After 16:00 – if the patient needs seeing the same day please contact the first on-call doctor for Ophthalmology via main switchboard on 01484-342000 or 01422-357171.

Saturday

Do not refer using this portal if the patient needs to be seen the same day, instead please contact the nurse emergency triage 09:00 – 13:00 on 01422 222414.

After 13:00 - if the patient needs seeing the same day please contact the first on-call doctor for Ophthalmology via main switchboard on 01484-342000 or 01422-357171.

Sunday

Do not refer using this portal if the patient needs to be seen the same day, instead please contact the first on-call doctor for Ophthalmology via main switchboard on 01484-342000 or 01422-357171.

Emergency Referrals

For all referrals that need to be seen within two weeks unless either skin cancer or Wet AMD.

[Create New Emergency Referral](#)

2WW Cancer Suspect Referrals

For all referrals where peri-ocular skin cancer is suspected.

[Create New Cancer Referral](#)

2WW Wet AMD Suspect Referrals

For all referrals where Wet AMD is suspected. Appointments are allocated automatically and no triage is performed.

[Create New Wet AMD Referral](#)

Routine Referrals

For patients that require a routine referral - greater than two weeks. Do not use for emergency referrals.

We do not accept referrals for Benign Skin Lesions or Chalazia without Prior Approval / IFRP. Please send to GP to obtain this and refer.

[Create New Routine Referral](#)

5.

same name,

Emergency Referral Form

NOTE: A red asterisk (*) indicates a field is mandatory, not optional. This field **MUST** be filled in.

Referrer Info*

Date of referral	Source of referral	Optometrist name	Optometrist GOC number
<input type="text" value="03/02/2020"/>	<input type="text" value="Please select a source"/>	<input type="text" value="Louise Corp"/>	<input type="text"/>
Practice name	Practice telephone	Practice email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Practice address	Practice location		
<input type="text"/>	<input type="radio"/> Halifax <input type="radio"/> Huddersfield		

Patient Info

Title	Forename(s) *	Surname *	Date of birth *
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NHS number	Hospital number		
<input type="text"/>	<input type="text"/>		
Preferred contact number *	Alternate contact number		
<input type="text"/>	<input type="text"/>		
Address *	Gender *		
<input type="text"/>	<input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Unspecified		
GP name *	GP practice *		
<input type="text"/>	<input type="text"/>		

6. Source of referral select either - Optometrist GOS18 or PEARS

7. Referral details -

Select 'urgency of referral – today, within 48hrs, within 7 days, within 2 weeks

Select 'main reason for referral' – acute conditions listed

Referral Details

Suggested urgency of referral *

Main reason for referral *

<input type="text"/>	<input type="text"/>
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8. Complete the referral details sections by clicking 'yes' or 'no' along with 'symptoms / findings' and 'previous ophthalmic history' (free text boxes)

Referral Details

Suggested urgency of referral *

Main reason for referral *

IOP measured? *

- Yes
 No

Visual acuity measured? *

- Yes
 No

Cup disc ratio measured? *

- Yes
 No

Spontaneous venous pulsation measured? *

- Yes
 No

Vitreous pigment present? *

- Yes
 No

9. File uploads – please include visual fields, OCT scans, fundus photography etc to support referral

10. Complete spectacles prescription

File Uploads

Browse for files using the below button.

Spectacles Prescription

Issued:	Right Eye						Left Eye					
	VA Previous	DS	DC	Axis	Prism	VA Today	VA Previous	DS	DC	Axis	Prism	VA Today
Distance	<input type="text"/>	<input type="text" value="0.0"/>	<input type="text" value="0.0"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="0.0"/>	<input type="text" value="0.0"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Near Add	<input type="text"/>	<input type="text" value="0.0"/>				<input type="text"/>	<input type="text"/>	<input type="text" value="0.0"/>				<input type="text"/>

11. Please add additional information as appropriate including request for interpreters and transport specific information

12. Tick privacy policy

13. Click submit

14. Click print page to save a copy of the referral or download as a document

+ Additional Info*

General Health and Medication

Special requirements

- Dementia
- Language Barrier
- Learning Difficulties
- Mobility Difficulties
- Special Needs
- Transport Required
- Vulnerable Patients

By ticking this box and continuing with this site you are consenting to us storing the information you have provided in line with our Privacy Policy and Cookie Policy.

Patient has consented to the above information:

1. Being submitted to hospital in order to process and provide appointments related to the above.
2. Being shared with other health professionals or administration staff within the hospital or community as appropriate to provide care in relation to the above.

2WW Cancer suspect referral

Additional information specific for this type of referral

1. Complete referrer and patient information as previous

2. Complete referrer details with regards suspect lesion

Referral Details

Approximate duration of lesion

Exact location of lesion
e.g. right upper lid, central, 5mm superior to lid margin

Approximate size of lesion in mm

Has this size changed? if so, by how much and over what time

Lesion is raised	Lesion is pigmented	Lesion has telangiectasia e.g. fine blood vessels	Lesion is ulcerated
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes, Uniform <input type="radio"/> Yes, Variable <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

3. Add any other findings, visual acuity, symptoms, previous ophthalmic history as previous

Any other findings of note
e.g. keratin horn, bleeding, loss of eyelashes

Visual acuity measured? *

Yes
 No

Symptoms/Findings	Previous ophthalmic history
<input type="text" value="Please do not use this form to refer any other problems."/>	<input type="text"/>

2WW Wet AMD Suspect Referral

Additional information specific for this type of referral

1. Complete referrer and patient information as previous

2. Complete referral details below – consistent with previous national paper referral form used previously

Referral Details

Affected Eye Right Left

Past history in either eye

Previous AMD Right Left

Myopia Right (DS) Left (DS)

Other (please specify)

Referral Guidelines

Presenting symptom in affected eye (one answer must be yes).

1. Visual loss Right Left

2. Spontaneously reported distortion Right Left

3. Onset of scotoma (or blurred spot) in central vision Right Left

4. Distance VA (best corrected)

Right	Left
<input type="text"/>	<input type="text"/>

5. Near VA

Right	Left
<input type="text"/>	<input type="text"/>

6. Macular drusen (either eye) Right Left

In the affected eye only, the presence of:

7. Macular haemorrhage Right Left

8. Subretinal fluid Right Left

9. Exudate Right Left

Additional Comments

3. File uploads and additional information can be submitted as previous
4. Click privacy policy and click submit

New routine Referral

Additional information specific for this type of referral

1. Complete referrer and patient information as previous
2. Select 'source of referral'
Click 'cataract scheme' for cataract scheme referrals

Click 'Glaucoma referral refinement scheme' for glaucoma scheme referrals
Click 'Optometrist GOS 18' for routine GOS referrals

Routine Referral Form

NOTE: A red asterisk (*) indicates a field is mandatory, not optional. This field **MUST** be filled in.

i Referrer Info *

Date of referral

03/02/2020

Source of referral

Please select a source

Optometrist name

Louise Corp

Practice name

Practice telephone

Practice en

Practice address

Practice location

- Halifax
- Huddersfield

3. Select most appropriate referral pathway

i Referral Details

Referral in specified speciality pathway *

Please select a referral pathway

- Cataract
- Cornea
- Emergency Eye Service
- General Ophthalmology (ONLY if does not come under any of the other pathways please)
- Genetics
- Glaucoma
- Macula (Macular Degeneration, Retinal Vein Occlusion, Diabetic Macular Oedema)
- Medical Retina (non-Macular Degeneration, non-Retinal Vein Occlusion, non-Diabetic Macular Oedema)
- Nurse Practitioner Cyst Clinic (Benign Skin Lesions - IFRP Approval By CCG Required / Chalazia - Prior Approval Required)
- Oculoplastics/Lacrimal
- Optometry Contact Lens
- Optometry refraction
- Orthoptics / Ocular motility
- Paediatric Ophthalmology
- Suspected Eyelid Skin Cancer
- Vitreo-retinal
- YAG Laser (Posterior Capsular Opacification ONLY)

Symptoms/Findings

Previous ophthalmic history

Note red text – please ensure the patient is suitable for referral, I speak to patients regarding visual impact to everyday life.

Referral Details

Referral in specified speciality pathway *

Cataract

Cataract present in right eye? *

- Yes
 No

Cataract present in left eye? *

- Yes
 No

Patient informed of presence? *

- Yes
 No

Patient is affected? *

- Yes
 No

Patient wishes to proceed with surgery if appropriate? *

- Yes
 No

NOTE: Patient is not suitable for referral as one or more of the above questions has been answered as no.

IOP measured? *

- Yes
 No

IOP right

IOP left

Instrument used

Please select an instrument.

Visual acuity measured? *

- Yes
 No

5. If 'glaucoma' pathway selected – please note patient's needs to compliant with NICE guidance

6. If 'referral source' 'Glaucoma Referral Refinement' chosen you will be prompted to complete the below that are in line with the current scheme requirements e.g. IOP repeat measures (date, time, method will be required), repeated visual fields documents to be attached.

Referral in specified speciality pathway *

All suspect Glaucoma referrals should be compliant with [NICE NG81](#) guidelines. Referrals that are not compliant will be rejected.

Has anterior chamber depth been assessed? *

Yes
 No

Visual field defect? *

Yes
 No

All referrals should be compliant with the requirements for the repeated measurements set out in the scheme. Referrals that are not compliant will be rejected.

Use the table below to enter details of the first and second sets of IOP checks

Date	Time	IOP right	IOP left	Instrument used
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="Please select an instrument."/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="Please select an instrument."/>

Visual acuity measured? *

Yes
 No

7. Symptoms, previous ophthalmic history, glasses prescriptions, file uploads and additional information, and privacy policy also need to be completed.

Any support please contact:

Louise Corp 07867902408
Natalka Drapan 07717800247
Emma Griffiths – Emma.Griffiths@cht.nhs.uk
Karnesh Patel – Karnesh.Patel@cht.nhs.uk