

**Doncaster Community Ophthalmology Service (Including GOS18)**

**Doncaster Clinical Commissioning Group**

**(As an alternative-please send us a referral letter with below details)**

Patient Name: \_\_

Address:

Tel: Mobile:

DOB: Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NHS number:

Reason for referral:

Referring GP/NP Name & Practice Address:

Allergic History:

Repeat Medication List attached?

PMH –Please attach Print out

Current sight eye test details if available-----

**Please send your referral either by:-**

* **Fax: 0845 0344761 Email:** **ophthalmologyservice@nhs.net**
* **Post: AMP Health Care, Spa Pool Road, Askern, Doncaster, South Yorkshire, DN6 0HZ**

***Please check that this form is completed fully to ensure that your patients' referral is processed promptly*.**

**In Case of any queries –please contact us on 01302 703443**

[***www.eyehealth.org.uk***](http://www.eyehealth.org.uk)



We ***MAY*** refer patients who need more in depth and prolonged treatment to Ophthalmology at Doncaster Royal Infirmary to save you and the patient cost in time and further appointments at your practice .

If you ***DO NOT*** wish us to refer on your behalf, please tick the below box.

I DO NOT wish this patient to be referred to Secondary care directly should further prolonged care were to be needed