

VES ONLY: Appointment Date & Time: _____
Triaged tests: VEP PERG ERG mfERG EOG DA

Date stamp:

UNIVERSITY HOSPITALS OF LEICESTER – DEPARTMENT OF MEDICAL PHYSICS

VISUAL ELECTRODIAGNOSTICS REQUEST

Patient Details / Label	
S/NHS Number:	
Surname:	
Forename:	
Date of Birth:	
Address:	
Tel No (REQUIRED):	
VES ONLY: Tiara upload <input type="checkbox"/> Triage <input type="checkbox"/> Booked <input type="checkbox"/> Letter <input type="checkbox"/> Interpreter <input type="checkbox"/> Reminder call <input type="checkbox"/> Apt Contact Entry <input type="checkbox"/> Report upload & Discharge <input type="checkbox"/>	

Prescription – Please mark for each eye & sign			
Single Check Eye Drops		OD	OS
Tropicamide	1 %		
Proxymetacaine Hydrochloride	0.5 %		
Sodium Chloride 0.9 % will be administered to aid accurate measurement as needed unless explicitly directed by the referrer			
Allergies / Contraindications (e.g. closed-angle glaucoma):			
Prescriber Sign & Date		Administered Sign & Date	

Hospital/Ward/Clinic:	Next Clinic Appointment:
Date:	
Tests will be performed $\geq 4/52$ from referral. To request more urgently, please contact us.	
Consultant:	NHS/ Private Patient / Research
Referrer:	New Diagnostic / Surveillance
Interpreter or access needs (e.g. large print, autism)? Y/N	Inpatient / Outpatient
What question do you hope to have answered?	Nystagmus? Yes / No
Query (tick as appropriate, further guidance overleaf) <input type="checkbox"/> Optic nerve pathology <input type="checkbox"/> Retinal dystrophy / degeneration <input type="checkbox"/> Unexplained vision loss <input type="checkbox"/> Macular/focal retina (+hydroxychloroquine monitoring) *visual fields must be included	
Best corrected VA (REQUIRED) (Snellen or LogMAR)	Recent refraction (REQUIRED)
OD	_____, _____ X _____
OS	_____, _____ X _____
For assistance or urgent referrals, please contact: 0116 258 5685 Or email: uhl-tr.edsophthalmologymailbox@nhs.net	

PLEASE FILL REFERRAL FORM WITH RELATED CLINICAL INFORMATION

- Best corrected **visual acuity and recent refraction**
- Anterior segments pathology
- VF loss (macular region only, peripheral region only, generalised visual loss, hemianopia, quadrantanopia)
- Retinal pathology; Genetic findings, e.g. CSNB, Best's, syndromes etc.; light sensitivity, night blindness
- Vascular related pathologies, e.g. CRAO, CRVO
- Possible suspicion of non-organic visual loss, malingering etc.
- Nystagmus (characteristics?)

A list of standard tests for commonly presenting conditions can be found on our website. The choice of tests may be modified in any particular case.

Please copy the Visual Electrophysiology Service in your clinic letter.

Please mark (and sign) the boxes for eye drops:

- **Dilation** and **anaesthetic eye drops** are required for all tests except the VEP and PERG.
- Please mark for each eye unless there is good reason not to administer eye drops in one eye.

Please advise your patients:

- **Updated refraction, distance and near vision spectacles** are required.

Please ensure the patient's contact details (incl. phone number) are up-to-date.

Please return the original form via post to:

Visual Electrophysiology Service
Medical Physics
Level 1, Sandringham Building
Leicester Royal Infirmary
LE1 5WW

For further copies of this form please contact the print room with the title or document ID