|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT DETAILS | | | | | | | | | |
| Name | Click or tap here to enter text. | | | Telephone | Click or tap here to enter text. | | | | |
| Address & Postcode | Click or tap here to enter text. | | | Date of Birth/CHI | Click or tap here to enter text. | | | | |
| Click or tap here to enter text. | | | GP Practice | Click or tap here to enter text. | | | | |
| Click or tap here to enter text. | | | Known allergies | Click or tap here to enter text. | | | | |
| Eligible for NHS Pharmacy First Scotland? | | | | Yes | | | No | | |
| Referral type | | | | Optometry to Pharmacy | | | Pharmacy to Optometry | | |
|  | | | |  | | | | | |
| CONSULTATION DETAILS e.g. presenting complaint(s) – symptoms, duration, actions already taken, other current medication? | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | |
| OPTOMETRY REPORT FOLLOWING CLINICAL ASSESSMENT | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | |
| TREATMENT REQUIRED | | | | | | | | | |
| To be supplied free of charge via NHS Pharmacy First Scotland Approved List | | | | | | | | | |
| Carbomer 0.2% eye gel 10g\* | | |  | Xailin Night eye ointment PF 5g | | | | |  |
| Carbomer 0.2% eye gel preservative free 10g\* | | |  | Hylo Night eye ointment PF 5g | | | | |  |
| \* please refer to Part 3 Eye Products of the Scottish Drug Tariff for eligible items and to the local Health Board Formulary for preferred brands | | | | Sodium cromoglicate 2% eye drops  (patients ≥ 2 years only) | | | | 5ml |  |
| Hypromellose 0.3% eye drop 10ml | | |  | 10ml |  |
| Chloramphenicol 1% eye ointment  (patients ≥ 2 years only) 4g | | |  | Chloramphenicol 0.5% eye drops  (patients ≥ 2 years only) 10ml | | | | |  |
| To be purchased via OTC sale (Pharmacy teams - no record on PMR is required in this instance) | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | |
| Duration of treatment Click or tap here to enter text. | | | | | | | | | |
|  | | | | | | | | | |
| Referrer’s name (Optometrist/Pharmacist)  Click or tap here to enter text. | | GOC/GPhC Number  Click or tap here to enter text. | | | | Referring Practice stamp (not required when being sent by secure email) | | | |
|  | | | |
| Contact number  Click or tap here to enter text. | | Date  Click or tap to enter a date. | | | |
| Referrer’s signature  (not required when being sent by secure mail) | | | | | |