NHS Pharmacy First Scotland Consultation Form Optometry ↔ Pharmacy Referral

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| --- | --- | --- | --- | --- |
| 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 ☐ |

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| 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 for the treatment of acute bacterial conjunctivitis only) 4g | ☐ | Chloramphenicol 0.5% eye drops  (patients ≥ 2 years for the treatment of acute bacterial conjunctivitis only) 10ml | | ☐ |
| Olopatadine 1mg/1ml eye drops (patients ≥ 3 years via PGD only) 5ml | ☐ |  | | |
| 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. | | | | |

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| 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) | |

Please discard in confidential waste once entered on PMR Version December 2023