TRIAGE FORM

Member of
Association of British
Dispensing Opticians

Patient Name:

DOB: NHS Number: (if known)

Patient Address:

Date:

Time:

Triage Completed by:

If referred to your practice please indicate where from:

Contact Telephone:

GP Name & Surgery:

Presented: ☐ Telephone ☐ Walk-in ☐ Referred

Patients Presenting Concerns: RE / LE / BE?

	YES	NO
Pain?	☐	☐
Condition worsening?	☐	☐
Redness?	☐	☐
Discharge?	☐	☐
Sensitive to light?	☐	☐
Change/Distortion in vision?	☐	☐
Loss of vision?	☐	☐
Contact lens wearer?	☐	☐
Flashes and/or floaters?	☐	☐
History of migraine?	☐	☐
Recent change in medication?	☐	☐
History of dry eye?	☐	☐

When did presenting symptoms start:	
Last sight test date:	

If the patient is experiencing any pain or discomfort: Score the level of pain/discomfort out of 10 *(where 0/10 is no pain/discomfort and 10/10 is excruciating pain/discomfort)* Also record where in the eye/eyes and any surrounding area the pain/discomfort is felt. If a foreign body is suspected record what and when/how it might have occurred.	

If the patient answered "yes" to any of the questions above please ask DO/CLO/Optometrist to add further details below: (If GOC registrant unavailable please refer to local guidelines or contact eye casualty dept and include any advice received below)

☐ **ADVICE & GUIDANCE:** (Please indicate any A&G issued)

☐ **REFER:** Please indicate to whom and level of urgency Emergency / Urgent / Routine:

☐ **BOOK SIGHT TEST:** (Please indicate date and time of appointment):

Registrant Review by:	GOC Number:	Date: