Emergency Eye Appointment Triage Form

(1) Patient details:	Date:	Time:	oWalk-in oPhone
First name:	Surname:	DOB: (DD/MM/YY)	/ /
		Referred by: oSelf oGP oPharmacist oOther	
Tel:	Address:		CL wearer: **oYes** oNo
GP name: Surgery: Written referral: o Yes o No		Usual optometrist: Date of last eye exam: / /	

(2) Patient concerns:	oRight eye	oLeft eye	oBoth eyes
Symptoms: Ever happened before? (give details):			
Is it painful? **oyes** ono	How is vision? **oworse** than normal osame as usual	Any redness? **oyes** ono	Sensitive to light? **oyes** ono
omild omod **Dsevere**	Describe:	omild omod **osevere**	omild omod **osevere**

(3) Information:	Symptoms started: o**Today** o**Yesterday** oWhen? Since started: o**Worse** oSame oBetter		
How sudden? **osudden** ogradual odon't know	Itching? omild omoderate osevere	Are the eyes sticky? oyellow / green ostringy white owatery	Any swelling? **oyes** ono
Any flashing lights? **Dyes** ono	Black specks in vision? **Dyes** ono	Double vision? **oyes** ono	Distorted vision? **oyes** ono

Optometrist's decision / Action taken: _____

_____

Sensitivity to LIGHT

PAIN

Blurred / distorted / missing / double VISION