WOOLWICH
OPTOMETRY

Emergency Ocular Triage Form

Name		Date		Time	

Email		Birth Date	

Primary contact #		cell☐	landline☐

Please describe your concern:

When did it start?		Any change?	Better☐	Worse☐	Same☐

Which Eye?	Right☐	Left☐	Both☐	Onset?	Sudden☐	Gradual☐

Have you initiated treatment?	Y☐	N☐	If yes, what?

Contact-lens use?	Y☐	N☐	If yes, do you wear contacts while asleep?	Y☐	N☐

Recent Eye Surgery?☐		Or Eye Injury?☐		It's happened before?☐

Check all symptoms that apply:

Vision Problem?	Y☐	N☐	If yes, noticed when looking...	Far☐	Near☐	Both☐

Double vision?☐	Light sensitivity?☐	Light *flashes*?☐	New/more *spots* in vision?☐

Eye(s) are red?☐	Watery eye(s)?☐	*Goopy* discharge from eye(s)?☐ Colour?

Something in eye(s)?☐	Burning?☐	Itch?☐	Pain?☐	New onset headache?☐

Please describe the severity of ***any*** of the symptoms experienced (a scale 0-10 can be used, zero being no symptom, and ten being the most severe symptom that you could imagine):

Any other relevant info?

Clinic Use Only	Reviewed☐ D/T	Book: Today☐ This Week☐ Tele☐ ER☐