# SYDNEY EYE HOSPITAL

**Eye Outpatient Department**
**Phone: 9382 7046 Fax: 9382 7354**
**Email: seslhd-sseh-eyereferrals@health.nsw.gov.au**

**Please refer to our website and 'INFORMATION FOR REFERRERS' prior to completing this form.**

**Referral Template**
*Please do not use this template for medical retina or glaucoma referrals*

***Each sub-specialty clinic has a strict set of inclusion criteria. Read our referral guidelines by scanning the QR code.*** **If this referral is deemed inappropriate or incomplete, you will be contacted ASAP. Waiting times for non-urgent appointments may be lengthy. Please refer patients to their closest public hospital eye clinic, if possible - see list on reverse side.**

## PATIENT INFORMATION

Surname: ________________________________ Given Names: __________________________________

Date of Birth_____/____ /__________ Gender: M / F

Address: ________________________________________________________________ Postcode: _______

Phone: (H) ____________________________ (M) ________________________________

Medicare No: _____________________________________

Language Spoken at home: _____________________________________ Interpreter Required? Yes / No

## REFERRER INFORMATION: *(to be completed by Optometrist or Ophthalmologist)*

Date: ____/____/_____ Referred by: _________________________________________________

Designation: Optometrist / Ophthalmologist

Address: ______________________________________________________ Postcode: ________

Phone: _____________________________ Fax: ____________________________

Email address: __________________________________________________________________

## REASON FOR REFERRAL: *(to be completed by Optometrist or Ophthalmologist)*

See list of sub-speciality clinics on reverse side

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______

## VISUAL ACUITY - test both eyes individually (*note if glasses or contact lenses are worn*)

**Best Corrected Visual Acuity:** **RIGHT** **PH:**

**LEFT** **PH:**

**Intraocular pressure:** **RIGHT** mmHg **LEFT** mmHg

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**RELEVANT EYE HISTORY:** *(Include any previous eye surgery, where and when it was done and by whom)*

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

**Is the patient currently under the care of a private ophthalmologist/another public hospital?**

☐ Yes and any relevant reports/correspondence are attached

☐ No

**Is the patient using any medications or eye drops?**

______________________________________________
______________________________________________
______________________________________________
______________________________________________

**Sub-specialty clinic list:**
General
Cataract (IOL)
Cornea
Oculoplastic
Ocular Oncology
Surgical Retina (VR)
Neuro-Ophthalmology
Inherited Eye Disease
Paediatric/Squint
Glaucoma – use glaucoma referral template
Medical retina/Uveitis – use MR referral template

**NSW Public Hospital Eye Clinic list:**

| Hospital | Fax |
|---|---|
| Bankstown Hospital | Fax: 9722 8398 |
| Liverpool Hospital | Fax: 8738 4585 |
| Royal Prince Alfred Hospital | Fax: 9515 7520 |
| Royal North Shore Hospital | Fax: 9463 1065 |
| Prince of Wales Hospital | Fax: 9382 2281 |
| Concord Hospital | Fax: 9767 6743 |
| Westmead Hospital | Fax: 8890 6117 |
| Sydney Children's Hospital | Fax: 9382 1461 |
| Westmead Children's Hospital | Fax: 9845 3457 |

Please return this referral template and relevant imaging to:
**seslhd-sseh-eyereferrals@health.nsw.gov.au**

*Not all referrals are accepted, and you and your patient will be notified ASAP if this is the case.*