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 – GLAUCOMA

Each sub-specialty clinic has a strict set of inclusion criteria.
The Glaucoma team will no longer accept referrals without an OCT and HVF, due to the overburdening of our consultant clinics with patients who do not meet our inclusion criteria for referral. If this referral is deemed inappropriate or incomplete, you will be contacted ASAP.

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

REFERRAL TO: GLAUCOMA

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

Date: ____/____/_____ Referred by: _____

Designation: Optometrist / Ophthalmologist

Address: _____Postcode:_____

Phone: _____ Fax: _____

Email address: _____

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

_____

_____

_____

_____

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

Cup to disc ratio: RIGHT LEFT

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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? If so, we will require a report from the specialist, outlining the patient's current treatment regime and recent history, with most recent OCT images and HVF results attached.

☐ No

☐ Yes and a report from the specialist and recent OCT images and HVF results are attached

Is the patient using any medications or eye drops?

_____
_____
_____
_____

Please attach relevant OCT and HVF to this referral in colour. If you are emailing this referral, please do not forget to attach them to your email.

☐ OCT attached

☐ HVF attached

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.