South Eastern Sydney Local Health District

Eye Outpatient Department
9382 7046

Referral Template – MEDICAL RETINA/UVEITIS

PLEASE REFER TO OUR WEBSITE and 'INFORMATION FOR REFERRERS' prior to completing this form.

www.seslhd.health.nsw.gov.au/sydney-eye-hospital/sydney-and-sydney-hospital-outpatients-department

Each sub-specialty clinic has a strict set of inclusion/exclusion criteria.

If this referral is deemed inappropriate or incomplete, you will be contacted ASAP by the Outpatient Department.

*****Please note, that the MR team will no longer accept referrals without a CLEAR, COLOURED fundus image, due to the overburdening of our consultant clinics with patients who do not meet our inclusion criteria for referral.*****

PATIENT INFORMATION

Surname: _____ First Name:_____

D.O.B.: ____/____ /_____ Gender: M / F

Address: _____ Postcode:_____

Contact Numbers: (H) _____ (M) _____

Medicare No: _____

Language Spoken at home:_____ Interpreter Required?: Yes* ☐ No ☐

REFERRAL TO:

Specialty (if known): **MEDICAL RETINA/UVEITIS**

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

Referral Date: ____/____/_____ Referred by: _____

Provider No: _____ Referrer Designation:_____

Address: _____ Postcode:_____

Telephone: _____ Fax: _____

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)*

Visual Acuity: **RIGHT:** **PH:** **LEFT:** **PH:**

Best Corrected Visual Acuity: **RIGHT:** **LEFT:**

EYE OUTPATIENT REFERRAL TEMPLATE – MEDICAL RETINA/UVEITIS

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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, please indicate reason for transfer to Sydney Eye Hospital and include any previous clinical notes or correspondence relevant to their condition.)*

_____
_____

Is the patient using any medications or eye drops? Yes ☐ No ☐ (*If Yes, please list below or attach medication chart or list)*

_____
_____

Please return this completed template by EMAIL to
seslhd-sseh-eyereferrals@health.nsw.gov.au
Please note that we will no longer accept referrals by fax from 1 January, 2020.

OFFICE USE ONLY – to be completed by MR/Uveitis Fellow or VMO at Sydney Eye Hospital

DATE TRIAGED: ____/____/_____

MR CLINIC - specify consultant if necessary

☐ 1 Week

☐ 4 Weeks

☐ 8 Weeks

☐ 12 Weeks

☐ Other, please specify:_____

SIGNATURE:_____

DESIGNATION:_____