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 – MEDICAL RETINA/UVEITIS

Please do not use this template for cataract, general or glaucoma referrals

There are new NSW state-wide referral criteria for selected conditions within the specialty of Ophthalmology. Visit the NSW Health website to learn more about this.
Read our referral guidelines by scanning the QR code above.

Surname: _____ Given Names: _____

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

Address: _____Postcode*:_____

**If postcode not in SESLHD catchment area please refer patient to their local public hospital eye clinic in the first instance. See list on back of this page.*

Phone: (H) _____ (M)_____

Email:_____

Medicare No: _____

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

Is patient of Aboriginal and/or Torres Strait Islander origin?

☐ NO ☐ Aboriginal origin ☐ Torres Strait Islander origin ☐ Both ☐ Declined to respond ☐ Unknown

REASON FOR MEDICAL RETINA/UVEITIS REFERRAL: *See NSW Ophthalmology Statewide Referral Criteria for conditions not routinely seen in public hospitals. This includes NPDR without oedema, RPE changes/dry MD.*

_____

_____

_____

_____

_____

REFERRER INFORMATION:

Date: ____/____/_____ Referred by: _____Optometrist/Ophthalmologist

Address: _____ Postcode:_____

Phone: _____ Fax: _____

Email address: _____

VISUAL ACUITY - test both eyes individually *(to be completed by Optometrist or Ophthalmologist)*

Best Corrected Visual Acuity: Right Eye: With Pinhole:
Left Eye: With Pinhole:

Intraocular pressure: Right Eye _____ mmHg Left Eye _____ mmHg

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

- Glasses / Contact Lens use
- Ocular Conditions and management history
- List all medications, *including eye drops*
- **Is the patient currently under the care of a private ophthalmologist/another public hospital? If yes, please attach any relevant correspondence/OCT.** Please note: we do not routinely provide appointments to patients able to continue anti-vascular endothelial growth factor (VEGF) treatment in the community.

_____

_____

_____

_____

Please attach relevant OCT or fundus imaging to this referral *in colour:*

☐ OCT attached or

☐ Fundus image attached

NSW Public Hospital Eye Clinics:

Bankstown Hospital Eye Clinic	Phone 9722 8380 Fax 9722 8398	SWSLHD-Bankstown-OutpatientServices@health.nsw.gov.au
Concord Hospital Eye Clinic	Phone 9767 5333 Fax 9767 6743	slhd-concordeyeclinic@health.nsw.gov.au
RPA Hospital Eye Clinic	Phone 9515 7532 Fax 9515 752	slhd-rpaeyeclinic@health.nsw.gov.au
Royal North Shore Hospital Eye Clinic	Phone 9463 1400 Fax 9463 1065	NSLHD-RNSH-Ophthalmology@health.nsw.gov.au
Sutherland Hospital Eye Clinic	Phone 9540 7286 Fax 9540 7304	seslhd-sutherland-outpatients@health.nsw.gov.au
Liverpool Hospital Eye Clinic	Phone 8738 4599 Fax 8738 4585	swslhd-liverpooleyeclinic@health.nsw.gov.au
Westmead Hospital Eye Clinic	Phone 8890 6668 Fax 8890 6117	e-Referrals only – see website
Prince of Wales Hospital Eye Clinic	Phone 9382 2261 Fax 9382 2281	
Sydney Children's Hospital Eye Clinic	Phone 9382 2261 Fax 9382 1461	schn-schoutpatientseyeclinic@health.nsw.gov.au
Westmead Children's Hospital Eye Clinic	Phone 9845 2261 Fax 9845 3949	schn-chw-eyeclinic@health.nsw.gov.au

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.