| FOR MEDICAL RECORD USE ONLY<br>-MEDICAL RECORD COPY – | SURNAME: MRN:<br>OTHER NAMES:<br>DOB: SEX: AMO: |
| --- | --- |
| **South Eastern Sydney Local Health District** | AFFIX PATIENT ID LABEL HERE |
| **Eye Outpatient Referral Template** | |

EYE OUTPATIENT REFERRAL TEMPLATE

The information requested on this referral form will be used to triage the patient into the correct specialty and time frame to be seen against a set of indicators pre-determined by our ophthalmologists. Please include as much information as possible in order to assist us to do this accurately. If you wish to discuss this in advance of completing this form please ring 93827046. Not all referrals will necessarily meet the pre-determined indicators and you will be advised as soon as possible if this referral is deemed unacceptable or insufficient.

**All fields are MANDATORY**.

**PATIENT INFORMATION**

MRN:________________________________________ Medicare Number:____________________Exp:______

Surname: ____________________________________ First Name:____________________________________

D.O.B.: ____/____ /______ Age: (years)________ Gender: M / F

Address: _____________________________________________________ Postcode:_____________________

Contact Numbers: (H) _____________________(M) _____________________ (W)______________________

Medicare Eligible: Yes ☐ No ☐ Medicare No: _______________________________________________________

**Language Spoken at home**:______________ **Interpreter Required?**: Yes* ☐ No ☐ *Please note we do not allow family to act as interpreters during medical consultations. A healthcare interpreter will be provided at the appointment if you tick 'Yes' in this field.

**REFERRAL TO:** *(please refer to service specialty listing overleaf)*

Clinician (if known):_________________________________________________________________________

Specialty (if known): _______________________________________________________________________

**REFERRER INFORMATION** *(to be completed by GP or Specialist)*

Referral Date: ____/____/______ Referred by: _____________________________________________________

Provider No: ____________________ Referrer Designation:___________________________________________

Address: _____________________________________________________ Postcode:_____________________

Telephone: _____________________ Fax: _____________________

E-Mail: ____________________________________________________________________________________

Signature: __________________________________________________________________________________

**REASON FOR REFERRAL:** *(to be completed by optometrist, GP or specialist)*

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

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

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

★Visual Acuity' – this is the benchmark our specialists use to decipher which patients need to be seen as a matter of urgency.

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| **Eye Outpatient Referral Template** | |

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

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

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

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Have any recent investigations taken place?** Yes ☐ No ☐ (*If Yes, please attach details and report)*

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**OFFICE USE ONLY**

DATE REFERRAL RECEIVED: ____/____ /______

DATE TRIAGED: ____/____ /______

TRIAGE URGENCY:

☐ 1 (1 Week)

☐ 2 (4 Weeks)

☐ 3 (8 Weeks)

☐ 4 (12 Weeks)

☐ 5 (Other- Please specify)

SIGNATURE:_________________________________

DESIGNATION:_________________________________

**SERVICE SPECIALTY LISTING**

| | |
|---|---|
| IOL (cataract) | Uveitis |
| General | Orthoptic/Humphrey visual field |
| Cornea | Neuro-ophthalmology |
| Glaucoma | Paediatrics/Strabismus |
| Surgical retina | Oncology |
| Medical retina | Oculo-plastics |

**Please return this completed template by fax to 93827354 or by mail to Sydney Eye Hospital Outpatients Department 8 Macquarie Street Sydney NSW 2000.**