Patient MRN (if known) ……

Referral date: …….

The Children's Hospital at Westmead

EYE CLINIC REFERRAL FORM

Please email the referral to SCHN-CHW-eyeclinic@health.nsw.gov.au or fax to Eye Clinic on 02 98453949.
Please complete **all sections of the form, clearly and legibly**.

REFERRALS CANNOT BE PROCESSED WITHOUT ALL NECESSARY INFORMATION.
Appointment details will be mailed to the patient. For all enquiries please telephone (02) 9845 2261.

Patient Details

Surname:……Given names:…….

Date of Birth:…… Sex: Male ☐ Female ☐

Address:……
…….

Medicare number:……

Next of Kin:……. Preferred contact number:……

Mobile:……Other:……

Language spoken at home……..

Interpreter required: Yes ☐ No ☐

Reason for referral

Please include onset, duration, symptoms, severity, vision, clinical findings and previous management. **Please note referrals lacking in information will not be given an appointment.**

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Referring Doctor Details

Surname:…….. Initial: ……. *Doctor's Stamp*

GP ☐ Paediatrician ☐

Optometrist ☐ Comm Health Nurse ☐

Other ……

Address……

……

Phone:……..Fax:……..

Email: ……..

Provider No: ……

Doctor's Signature…… Date …….