

South Eastern Sydney Local Health District

Eye Outpatient Department
9382 7046

Referral Template –
GLAUCOMA

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, the glaucoma team will no longer accept referrals without a CLEAR, COLOURED fundus image and HVF, 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): **GLAUCOMA**

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:

IOP : RIGHT: LEFT: measured with: _____

CD 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, 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)

HVF attached

Fundus image attached

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 Glaucoma Fellow or VMO at Sydney Eye Hospital

DATE TRIAGED: ___/___/___

GLAUCOMA CLINIC -specify consultant if necessary OR GLAUCOMA INVESTIGATION CLINIC

1 Week

4 Weeks

8 Weeks

12 Weeks

Other, please specify: _____

SIGNATURE: _____

DESIGNATION: _____