**DATE**

* To make a referral, please fax this page to the Outpatient reception, fax number: **9722 8398**
* **Please note: Patients are ineligible if they have any of the conditions listed over the page**
* **Please note *all fields are mandatory*** and must be completed or this referral may not be accepted

**From: (please circle) Optom/GP/Ophth. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address, Fax no. and Provider No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GP’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address, Fax no. and provider No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Please provide ID label if available**

**Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code: \_\_\_\_\_\_\_\_\_**

**Contact No. (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No. (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medicare No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare expiry date: \_\_\_/\_\_\_/\_\_\_**

**Interpreter required: [ ] Yes, Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has the patient previously visited this hospital? [ ] Yes [ ] No**

**Onset of problem: [ ] Sudden [ ] Gradual [ ] Incidental finding**

Please mark ‘X’ in relevant boxes

**Condition Suspected**

Cataract [ ] Eye trauma [ ]

Sudden loss of vision [ ] Squint [ ]

Glaucoma [ ] Retinal problems [ ]

Retinal detachment [ ] Other:

Iritis [ ]

**Risk Factors**

Diabetes [ ] Previous eye condition [ ] Yes [ ] No

Hypertension [ ] If yes, please state:

**Symptoms**

Pain [ ] Floaters [ ]

Loss of vision [ ] Flashing lights [ ]

Diplopia [ ] Duration:

Watery eyes [ ] Other:

**Clinical Examination**

**Best corrected Visual Acuity: Right: \_\_\_\_\_\_\_\_\_\_ Left: \_\_\_\_\_\_\_\_\_\_**

IOP: Right: Left: PERL [ ] Yes [ ] No

Images attached [ ] Yes [ ] No

Proptosis [ ] Fluorescein stain [ ] Yes [ ] No

Eye movements normal [ ] Yes [ ] No Red eye [ ] Yes [ ] No

Fundoscopy normal [ ] Yes [ ] No

Comments / Other Reasons for Referral

\_\_\_ \_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ineligible Ophthalmology Conditions**

The following conditions are **not** routinely seen at Bankstown – Lidcombe Hospital and may be appropriately managed by a local ophthalmologist or optometrist until they reach the clinical thresholds identified in these referrals guidelines.

|  |  |
| --- | --- |
| **Condition** | **Description** |
| **Age related macular degeneration** | Family history but asymptomatic |
| **Blepharitis** | Chronic (Not severe) |
| **Conjunctivitis** | No other signs or symptoms |
| **Cornea** | No surgical cornea/corneal transplantation |
| **Contact Lens** | New or replacement |
| **Diabetes** | Newly diagnosed / for screening  No evidence of diabetic retinopathy and or visual acuity better than 6/12 corrected |
| **Dry eyes** |  |
| **Epiphora (watery eye)** | Intermittent watery or blocked tear duct |
| **Epiretinal Membrane** |  |
| **Headaches** | When reading/migraine with no ophthalmic symptoms  Tension headaches with no ophthalmic symptoms |
| **Itchy eyes** | Longstanding with no lid or corneal involvement |
| **Lids** | No ocular plastics consultation |
| **Pterygium** | Asymptomatic and or visual acuity better than 6/12 corrected |
| **Red eye** | Chronic /no associated visual loss or pain |
| **Refraction** |  |
| **Trichiasis** | eyelash removal |
| **Visual acuity for cataract** | Better than 6/12 corrected |