AlfredHealth

UR

☐ Alfred ☐ Sandringham ☐ Caulfield

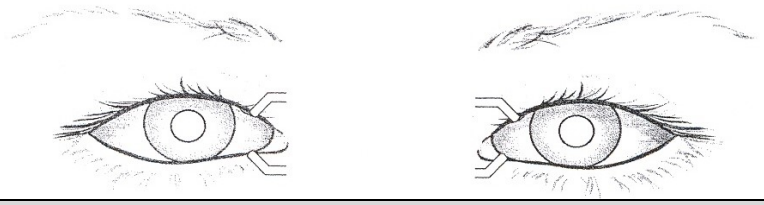
REFERRAL TO OPHTHALMOLOGY CLINIC

Date of Referral					
Patient Details					
Family Name		Given Name			
Date of Birth		Sex: ☐ Female ☐ Male			
Address					
Telephone		Email			
Medicare No		Reference No		Expiry	
Interpreter	☐ Yes ☐ No	Language			
Aboriginal or Torres Strait Islander		☐ Yes, list		☐ No ☐ Not specified	
Contact Person	Name				
	Relationship		Telephone		
Disabilities					

Reason for referral *(severity, duration, physical findings)*

Relevant History and current medications

Complete this assessment

Visual Acuity		Pupils	Eye movements
Right	**Left**		
☐ 6/…….	☐ 6/…….	☐ Round, equal & reactive to light	☐ Normal
☐ HM	☐ HM	☐ Pupil Abnormality	☐ Restricted, *specify*
☐ LP	☐ LP	☐ Right ☐ Left	
☐ NPL	☐ NPL		
Illustrate as appropriate 			☐ Diplopia, *specify*

Referrer Details					
Referrers Name		Discipline			
Address					
Telephone		Fax		Email	
Provider No		Copies to			

- Attach all relevant investigation reports – even if NAD
- Your patient will be contacted direct with appointment details
- Enquiries: Clinic Coordinator – T 9076 2025
- **Return referral to:** **Fax 9076 6938 or** outpatient@alfred.org.au

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