THE SUTHERLAND HOSPITAL EYE CLINIC
OPTOMETRIST DIABETIC RETINOPATHY REFERRAL

Centre for Eye Health

The Eye Clinic
Sutherland Hospital
Kingsway
Caringbah NSW 2229

Please **FAX** completed referral form to the Eye Clinic on **9540 8067**
For administrative enquiries: phone **9540 7067**

For **urgent referrals**, please contact the On-Call Ophthalmology Registrar via switchboard on **9540 7111**

Please note: Depending on the nature and urgency of the referral, patients will be assessed on site by either the Ophthalmology Service or Centre for Eye Health.

This service provides ophthalmology-led diabetic retinopathy assessment with access to a comprehensive range of imaging equipment. Due to limited hospital resources, please consider appropriate alternatives prior to referring to this service. Please avoid referring patients who are currently under the care of an ophthalmologist for their diabetic retinopathy management and/or who are undergoing treatment for their diabetic retinopathy elsewhere.

PATIENT INFORMATION

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Other: _____

Surname: _____

First Name: _____

Date of Birth: _____/_____/_____

Address: _____

_____

Medicare Number: _____

Ref # _____ **Expiry:** _____/_____

Phone Number: (home) _____

(work)_____**(mobile)**_____

Email: _____

☐ **Interpreter required: Language**_____

☐ **Aboriginal or Torres Strait Islander**

CLINICAL INFORMATION

VISUAL SYMPTOMS/PAST OPHTHALMIC HISTORY

Has been reviewed by an ophthalmologist in the past 2 years: ☐ Yes ☐ No

If yes: Name of ophthalmologist _____ Date last seen: _____

OPHTHALMIC EXAMINATION FINDINGS

Refraction/BCVA: Right _____ VA _____ Left _____ VA _____

DIABETIC STATUS

☐ Type 1 ☐ Type 2 Duration _____ years HbA1c (if known) _____ (date: _____)

OTHER RETINOPATHY RISK FACTORS ☐ Hypertension ☐ Hyperlipidaemia ☐ Smoking

☐ Pregnancy ☐ Renal Dysfunction ☐ Other Diabetic Complications_____

OTHER MEDICAL HISTORY (attach if required)

MEDICATIONS (attach if required)

ALLERGIES

OTHER HEALTH CARE PROVIDERS

GP (required) _____

Endocrinologist _____ Other_____

REFERRING OPTOMETRIST

Name: _____

Address: _____

_____

Provider No.: _____

Referral Date: ____/____/_____

Signature: _____

TSH Use Reg VMO CFEH TF Rev / /