THE SUTHERLAND HOSPITAL EYE CLINIC
GP DIABETIC RETINOPATHY SCREENING 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 diabetic retinopathy assessment with an emphasis on **patients who are not currently receiving appropriate retinopathy screening as per clinical guidelines**. Please avoid referring patients who are currently receiving appropriate screening by their ophthalmologist or optometrist. Patients who are undergoing treatment for diabetic retinopathy elsewhere should not be referred to this service.

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 not received retinopathy screening in past 2 years (time since last screening _____)

DIABETIC STATUS

☐ Type 1 ☐ Type 2 Duration _____ years

Control: Excellent / Good / Fair / Poor HbA1c _____ (date: _____)

OTHER RETINOPATHY RISK FACTORS ☐ Smoking: Current / Former

☐ Hypertension - Control: Excellent / Good / Fair / Poor ☐ Renal Dysfunction ☐ Pregnancy

☐ Hyperlipidaemia ☐ Other Diabetic Complications_____

OTHER MEDICAL HISTORY (attach if required)

MEDICATIONS (attach if required)

ALLERGIES

OTHER HEALTH CARE PROVIDERS

Optometrist _____ Endocrinologist _____

Other_____

GENERAL PRACTITIONER

Name: _____

Address: _____

_____

Provider No.: _____

Referral valid for: ☐ 12 months ☐ Other_____

Referral Date: ____/____/_____

Signature: _____

TSH Use Reg VMO CFEH TF Rev / /