



THE SUTHERLAND HOSPITAL EYE CLINIC

OPTOMETRIST DIABETIC RETINOPATHY REFERRAL



The Eye Clinic
Sutherland Hospital
Kingsway
Caringbah NSW 2229

Please **FAX** completed referral form to the Eye Clinic on **9540 7304**
 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: _____