THE SUTHERLAND HOSPITAL EYE CLINIC
GP DIABETIC RETINOPATHY SCREENING REFERRAL

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

☐ Hypertension-Control: Excellent Good Fair Poor

☐ Smoking: Current Former

☐ 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 / /