



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

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

Endocrinologist _____

Optometrist _____ Other _____

GENERAL PRACTITIONER

Name: _____

Address: _____

Provider No.: _____

Referral valid for: 12 months Other _____

Referral Date: ____/____/____

Signature: _____