



# 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 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:** \_\_\_\_\_