Royal Victoria Eye and Ear
Ophthalmology Referral Form

Royal Victoria Eye and Ear Hospital.
Adelaide road,
Dublin 2.

☐ **Outpatients Referral**
Fax this form to 01 6785462 **or post** to **Outpatients Dept**. Do not give this form to patient to hand deliver.

☐ **Emergency Referral**
Give patient letter of referral to bring to A&E Dept.

- **All fields must be filled in. Incomplete forms may not be accepted.**
- **Chronic, non-urgent conditions should be referred directly to the Outpatients Dept.**

From: Name of GP:_____ Address:_____

Tel no: _____ Date of Referral:_____

Patient Details:

Name: _____ DOB: _____ Gender: M ☐ F ☐

Address: _____ Tel No (home): _____

Post code: _____ Tel No (work/mobile): _____

Medical Card Number: _____ Interpreter required: Yes ☐ No ☐

If Yes, First language: _____

Special needs: Yes ☐ No ☐ if yes, please give details: _____

Health Insurance Company: Insurance No. Plan:

Has this patient attended previously visited the hospital before? Yes ☐ No ☐

Reason for referral: _____

_____

Is vision affected? Yes ☐ **No** ☐

Affected eye(s):
Right: ☐
Left: ☐

Onset:
Sudden ☐
Gradual ☐
Incidental finding ☐

Approximate Duration:
Days ☐
Weeks ☐
Years ☐

Examination: _____

_____

_____

Best corrected visual acuity: Right eye: **Left eye:**

Medical history: _____

_____

_____

Medications: _____

_____

ALLERGIES

Practice stamp and M.C.N

HOSPITAL USE ONLY

ASSESSED BY:

OUTCOME:

Urgent ☐ **Routine** ☐ **Soon** ☐