



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):	Onset:	Approximate	
	Right: <input type="checkbox"/>	Sudden <input type="checkbox"/>	Duration:
	Left: <input type="checkbox"/>	Gradual <input type="checkbox"/>	Days <input type="checkbox"/>
	Incidental finding <input type="checkbox"/>	Weeks <input type="checkbox"/>	
		Years <input type="checkbox"/>	

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