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|  *Ophthalmology Outpatient Referral Form* |
| Patient Name: |  | **Hospital:**  | Royal Victoria Eye & Ear Hospital |
| Date of Birth: |  | **GP/Referrer Name:** |  |  |
| Address: |  | **GP/Referrer Address:**  |  |  |
| Tel/Contact Number: |  |  |  |  |
| Gender: |  **Female □ Male □** |  |  |  |
| Referral Priority: | □ Urgent □ Semi-Urgent □ Non-Urgent High clinical/social needs □ Yes □ No  Interpreter required □ Yes □ No If Yes, First language:  |
| Reason for referral |  |
| Vision Affected: |  **Yes □ No □** | **Onset:**  |  |
| Affected Eye(s): |  | **Symptom Duration:**  |  | days/weeks/months |
| Best Corrected Visual Acuity: | Right Eye:  |  | Left Eye:  |  |
| Additional Relevant Information: |  |  |  |  |
| General History: | Previous Hospital Attendance: |  |  |  |
|  | History of Presenting Complaints: |  |  |  |
|  | History of Past Illness: |  |  |  |
|  | History of Surgical Procedures: |  |  |  |
|  | Allergies/Adverse Medication Events: |  |  |  |
|  | Relevant Family History: |  |  |  |
| Clinical Exam: |  |  |  |  |
|  |  |  |  |  |
| Investigations: |  |  |  |  |
|  |  |  |  |  |
| Next of Kin: (name, contact no.& relationship) |
|  |  |
| Current Medication: |  |  |  |  |
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