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| *RVEEH Ophthalmology Emergency Department 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: | □ Emergency □ Urgent □ Semi Urgent | | | | | | | | | | | | | | | | |
| Preferred Consultant: | | Eye / Ophthalmology Emergency Department | | | | | | |  | | | | | |  | | |
| Reason for referral/  Anticipated outcome: | |  | | | | | | | | | | | | | | | |
| Vision Affected: |  | | | **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: | | |  | | | |  | | | | | |  | | | |
| Pulse: | bpm | | | | **BP Systolic/Diastolic:** | | | | | | / | | | | | mm/hg | |
| Weight: | Kg | | | |  | | | | | |  | | | | |  | |
| Infection status: |  | | | |  | | | | | |  | | | | |  | |
| Clinical Exam: | |  | | |  | | | | | |  | | | | |  | |
|  | |  | | |  | | | | | |  | | | | |  | |
| Lab Investigation: | |  | | |  | | | | | |  | | | | |  | |
| Rad Investigation: | |  | | |  | | | | | |  | | | | |  | |
| Social History: | Drinker Yes / No | | | Smoker Yes / No | | | |  | | | | | |  | | | |
| Next of Kin: (name, contact no.& relationship) | | | | | | | | | | | | | | | | | |
| Current Medication: | Patient on Anticoagulants: Yes / No | | | | | | | | | | | | | | | | |
|  | Current Medication: | |  | | | |  | | | | |  | | | | | |
|  |  | |  | | | |  | | | | |  | | | | | |
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