THE ROYAL VICTORIA EYE AND EAR HOSPITAL DUBLIN

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: relationship) **(name, contact no.&**

Current Medication: