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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: | |  | | |  | | | | |  | | | |  | |
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| Investigations: | |  | | |  | | | | |  | | | |  | |
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| Next of Kin: (name, contact no.& relationship) | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | |
| Current Medication: |  | |  | | | |  | | | |  | | | | |
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