# Ophthalmology Referral Form

☐ **Outpatients Referral:** **Fax** this form to 01 6785462 **or post** to Outpatients Dept

☐ **Emergency Referral:** Give patient letter of referral to bring to A&E Dept

**From:**

Name of GP: Address:

Tel no: Date of Referral:

**Patient Details:**

Name: DOB: Gender:

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:

**Reason for referral:**

**Is vision affected?** **Yes** ☐ **No** ☐

| *Affected eye(s)* | *Onset* | *Approximate duration* |
|---|---|---|
| Right ☐ | Sudden ☐ | Days ☐ |
| Left ☐ | Gradual ☐ | Weeks ☐ |
| | Incidental finding ☐ | Years ☐ |

**Examination:**

Best corrected visual acuity RE LE

Clinical findings:

**Medical History:**

**Medications:**

**Allergies:**

*PRACTICE STAMP AND M.C.N.*

*HOSPITAL USE ONLY*

**ASSESSED BY:**

**OUTCOME:**

**Urgent** **Routine** **Soon**