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| Royal Melbourne Hospital Ophthalmology Referral form |  | **Referral Date:**    /    /  **GP/Optom Review Date:**    /    /  **Feedback Requested:**  Yes  No |

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| **Referral to:**  A/Prof Elaine Chong  Retinal Consultant  Dr Alp Atik  Dr Nathan Wong  **Address**: Department of Ophthalmology,  Royal Melbourne Hospital  300 Grattan Street, Parkville, Victoria  **Phone:**  **Fax:** (03) 9342 4234  **Email:** |  | **Referring Medical Practitioner** (stamp):  Name:  Provider number:  **Consent to referral and sharing of relevant information:**  Yes  No |

Service requested & reason for referral

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Patient / client details

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| --- | --- | --- |
| Name:  Date of Birth:    /    /  Preferred name/s:  Sex:  Male  Female  Title:  Mr  Mrs  Ms  Miss |  | Address:    Phone:       Work:  Mobile:  Email: |
| Alternative Contact/ NOK:       Indigenous Status: | | |
| Interpreter required:  Preferred language is:  Pension Card Number: |  | DVA Number:  Insurance:  Medicare Number: |

Relevant history, duration of symptoms, visual requirements

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Vision and refraction

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|  | Unaided  Acuity | Corrected  Acuity | Pinhole | Sphere | Cylinder | Axis | Prism | Base | Add |
| RE |  |  |  |  |  |  |  |  |  |
| LE |  |  |  |  |  |  |  |  |  |
| **IOP** |  | |  | | | | | | |
| RE mmHg |  | |
| LE mmHg |  | |