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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

|  |  |  |
| --- | --- | --- |
| Name:      Date of Birth:    /    /    Preferred name/s:      Sex: [ ]  Male [ ]  FemaleTitle: [ ]  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 |       |