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**THE SUTHERLAND HOSPITAL EYE CLINIC**

**GP DIABETIC RETINOPATHY SCREENING REFERRAL**

**The Eye Clinic**

Please **FAX** completed referral form to the Eye Clinic on **9540 8067**

For administrative enquiries: phone **9540 7067**

**Sutherland Hospital**  
**Kingsway**  
**Caringbah NSW 2229**

For **urgent referrals**, please contact the On-Call Ophthalmology Registrar via switchboard on **9540 7111**

Please note: Depending on the nature and urgency of the referral, patients will be assessed on site by either the Ophthalmology Service or Centre for Eye Health.

This service provides diabetic retinopathy assessment with an emphasis on **patients who are not currently receiving appropriate retinopathy screening as per clinical guidelines**. Please avoid referring patients who are currently receiving appropriate screening by their ophthalmologist or optometrist. Patients who are undergoing treatment for diabetic retinopathy elsewhere should not be referred to this service.

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| **PATIENT INFORMATION**  **Title:**  Mr  Mrs  Ms  Other: \_\_\_\_\_\_\_\_\_\_  **Surname:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of Birth:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Medicare Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Ref #** \_\_\_\_\_\_  **Expiry:** \_\_\_\_\_/\_\_\_\_\_\_\_  **Phone Number: (home)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(work)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(mobile)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Interpreter required: Language**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Aboriginal or Torres Strait Islander** |

# CLINICAL INFORMATION

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| **VISUAL SYMPTOMS/PAST OPHTHALMIC HISTORY**  ☐ Has not received retinopathy screening in past 2 years (time since last screening \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | |
| **DIABETIC STATUS**  ☐ Type 1 ☐ Type 2 Duration \_\_\_\_\_\_\_\_\_\_ years  Control: Excellent / Good / Fair / Poor HbA1c \_\_\_\_\_\_\_\_\_\_\_ (date: \_\_\_\_\_\_\_\_\_ ) | |
| **OTHER RETINOPATHY RISK FACTORS** ☐ Smoking: Current / Former  ☐ Hypertension - Control: Excellent / Good / Fair / Poor ☐ Renal Dysfunction ☐ Pregnancy  ☐ Hyperlipidaemia ☐ Other Diabetic Complications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **OTHER MEDICAL HISTORY** (attach if required) | |
| **MEDICATIONS** (attach if required) | **ALLERGIES** |
| **OTHER HEALTH CARE PROVIDERS** Endocrinologist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Optometrist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **GENERAL PRACTITIONER**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provider No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referral valid for: ☐ 12 months ☐ Other\_\_\_\_\_\_\_\_\_\_  **Referral Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_**  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

TSH Use Reg VMO CFEH TF Rev / /