the children's hospital at Westmead

The Sydney children's Hospitals Network

Patient MRN (if known): _____

Referral date: _____

# Eye Clinic Referral Form

Retain original for your own file. Fax to Eye Clinic on **(02) 9845 3949.**

**Please complete all sections of the form, clearly and legibly.**

**REFERRALS CANNOT BE PROCESSED WITHOUT ALL NECESSARY INFORMATION.**

Appointment details will be mailed to the patient. For all enquiries please telephone **(02) 9845 2261.**

## PATIENT DETAILS

Surname: _____ Given names: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____

_____

Medicare number: _____

Next of Kin: _____ Preferred contact number: _____

Mobile: _____ Other: _____

Language spoken at home: _____

Interpreter required: ☐ Yes ☐ No

## REASON FOR REFERRAL

Please include onset, duration, symptoms, severity, vision, clinical findings and previous management. **Please note referrals lacking in information will not be given an appointment.**

_____

_____

_____

_____

_____

Preferred Consultant (if applicable): _____

## REFERRING DOCTOR DETAILS

Surname: _____ Initial: _____ Doctor's Stamp:

☐ GP ☐ Paediatrician

☐ Optometrist ☐ Comm Health Nurse

Other: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

Provider No: _____

Doctor's Signature: _____ Date: _____

Modified 24 September 2019

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