Return Fax Attention to:
Austin Health Eye Clinic
Clinic E
FAX 9496 2097

OPHTHALMOLOGY REFERRAL

PATIENT DETAILS	**REFERRER DETAILS**
Name: DOB:	Name:
Address:	Address:
Phone No.:	Phone No.:

*****Referrals to the Ophthalmology Department must include an Optometrist's or Ophthalmologist's Report*****

REASON FOR REFERRAL:		
Urgency of Referral: Urgent/Semi-urgent/Routine (Please circle)		
Symptoms and duration: Impact on ADL:		
Visual Acuity: Unaided Best corrected Refraction	**Right:**	**Left:**
IOP (mmHg)	Right:	Left:
Is there a relative afferent pupillary defect or pupil abnormality?	No/Yes (RE/LE, describe)	
Anterior segment examination - Normal/Abnormal (Describe below)		
Fundus examination - Normal/Abnormal (Describe below)		
General Health (Please attach Health Summary)		
Please attach images/results If available and indicate which.	○ OCT mac or disc ○ Fundus photo ○ Corneal topography ○ Visual field ○ Other	

For **Emergency Referrals**, contact the on-call Ophthalmology Registrar via Switchboard on 9496 5000.

Please refer to the **Austin Ophthalmology Referral Guidelines**:
https://www.austin.org.au/Assets/Files/Referral%20Guidelines%2022%20Apr%202020.pdf

Referrer's signature:	**Date:**