Ophthalmology Referral

Referral

Date of Referral:	-	☐ **Left eye**	☐ **Right eye**	☐ **Bilateral**
Brief reason for referral:	-			

Referral to

Organisation:	Wide Bay Hospital and Health Service
Clinic Referred to:	Referral Room - Ophthalmology
Address:	PO Box 34, Bundaberg QLD 4670
Phone:	(07) 4303 8233
Fax:	(07) 4303 8299
Email:	WBHHS-Ophthalmology@health.qld.gov.au

Referral from

Referring clinician:	-		
Organisation:	-		
Address:	-		
Phone:	-	**Fax:**	-
Email:	-		
Provider Number:	-		

Patient details

Title:	-	**Surname:**	-	**Given Name:**	-
DOB:	-	**Sex:** ☐ **Female** ☐ **Male**			
Address:	-				
Suburb:	-	**State:**	-	**Postcode:**	-
Home Phone:	-	**Mobile:**	-		
Patient's healthcare details					
Medicare No.:	-	**ID no.**	-	**Expiry:**	-
Private Health Insurance ☐ **Yes** ☐ **No** ☐ **Unknown**				**Schedule:**	-
Health Fund:	-	**Member No.:**	-		
Pension Card No.:	-			**Expiry:**	-
Veteran Affairs No.:	-	☐ **Gold** ☐ **White**		**Expiry:**	-
☐ **Compulsory Third Party** ☐ **Work Cover** ☐ **Department of Defence**					
Patient's usual GP details					
Name:	-	**Practice Name:**	-		
Address:	-				
Suburb:	-	**State:**	-	**Postcode**	-
Phone:	-	**Fax:**	-		

WBHHS Referral Unit Only	**Date received:**		**Referral validity duration:**	
	Entered HCBIS date:		**Removed HBCIS date:**	

Patient Clinical Information

Current Medications

Drug Name	Strength	Dosage	Reason	Last Script

Warning/Alerts

Allergy/Adverse Reactions	Reaction

Past Clinical History

Relevant medical and surgical history

Date	Condition/Procedure

Optometrist Assessment

VA & BCVA Required

Right	Left	Pupils
VA 6/ BCVA 6/	VA 6/ BCVA 6/	☐ Round, equal & reactive to light ☐ Pupil Abnormality RAPD ☐ Yes ☐ No
☐ **HM** ☐ **LP** ☐ **NPL**	☐ **HM** ☐ **LP** ☐ **NPL**	**Eye Movement**
		☐ Normal
Intra ocular pressure (IOP):		☐ Restricted – Specify:
Cup Disc Ratio:		
		☐ Restricted – Specify:
Refraction if available (mandatory for cataracts)		

Verification			
Doctor's Full Name:			
Signature:		**Date:**	