The Lion's Eye Clinic for Children

REFERRAL FORM

SYDNEY CHILDREN'S HOSPITAL RANDWICK

Retain original for your own file. Fax to Eye Clinic on (02) 9382 0890
Please complete **ALL** sections of the form, clearly and legibly.

Appointment details will be mailed to the patient. Please ensure patient address is current.
For all enquiries please phone (02) 9382 2261

Date Referral Received:

REFERRAL TO:

Dr Kimberley Tan ☐ Dr Mark Jacobs ☐
Dr Hughie Tsang ☐

DATE OF REFERRAL: ___________________

DURATION OF REFERRAL:
12 months ☐ Indefinite ☐

PATIENT DETAILS

Surname: ______________________________ Given Name/s: ______________________________

Date of Birth: ____________________ Sex: Male ☐ Female ☐

Address: ____

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Medicare Number: _________________________________

Next of Kin: _______________________________________

Preferred contact number: ___________________________

Mobile: __________________________ Other: _____________________________

Language spoken at home: _______________________ Interpreter needed: Yes ☐ No ☐

REASON FOR REFERRAL

Strabismus - intermittent ☐
constant ☐
Watery eye/ blocked tear duct ☐
Ptosis ☐
Chalazion/ Stye ☐
StEPS ☐
Other ☐

Affected eye: Right ☐ Left ☐

Onset:
Sudden ☐ Gradual ☐
Since birth ☐ Incidental finding ☐

Approximate Duration:
_____________ days/weeks/months/years

Progression: Yes ☐ No ☐

Referral Details
Please include onset, duration, symptoms, severity, clinical findings, relevant family history, previous management and if possible vision

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REFERRING DOCTOR DETAILS

Surname: _______________________ Initial: _____________

Doctor's Stamp

Address: ____

____

Phone: ________________________ Fax: ________________

Email: ____

Provider Number: ____________________________________

Doctor's Signature: ___________________________________

OFFICE USE ONLY

Triage category: ______________________________________ Consultant Clinic: _______________

Triage clinician initials: __________________________________ Date: _________________________