The Alfred Outpatient Ophthalmology Referral

Please fax this form to 9076 6938

or post to: Outpatient Department, The Alfred, PO Box 315, Prahran 3181

Alfred Hospital UR: ☐☐☐☐☐☐☐☐☐☐ Date: ___/___/_____

Patient's Title: ☐ Mr / ☐ Mrs / ☐ Ms / ☐ Miss

Surname: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Given Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

DOB: ☐☐☐☐☐☐☐☐

Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Postcode ☐☐☐☐

Phone Home: _____ Work: _____ Mob: _____

Interpreter Required: Yes ☐ Language: _____ No ☐

Medicare Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Line Number ☐

Medicare expiry date: ☐☐ - ☐☐☐☐

Clinical Reason for Referral: (severity, duration, physical findings)

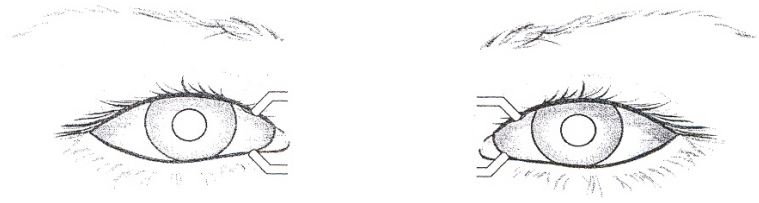
Relevant Investigation Results: (Please attach even if NAD)

Relevant Past History and current medications:

PLEASE COMPLETE THE FOLLOWING ASSESSMENT

VISUAL ACUITY		PUPILS	EYE MOVEMENTS
RIGHT	LEFT		
☐ 6/.....	☐ 6/.....	☐ Round, Equal & Reactive to Light	☐ Normal
☐ HM	☐ HM	☐ Pupil Abnormality	☐ Restricted - specify
☐ LP	☐ LP		☐ Diplopia - specify
☐ NPL	☐ NPL	Circle: RIGHT LEFT	

ILLUSTRATE AS APPROPRIATE:



Doctor's Name: _____

Address: _____

City: _____ P/code: _____

Phone: _____ Fax: _____

Provider Number: _____

Doctor's Stamp

All Phone Inquiries can be directed to: 9076 2025