Learning on TAP

Primary eye care
Referral form

[Service provider logo]	Date ✎
	Referral location ✎
	Urgent: Yes ☐ No ☐

Dear eye health professional/diabetes service/other ✎ _____ (*circle relevant),*

Re:

Family name ✎	Given names ✎
Date of birth/age ✎	Gender: Male ☐ Female ☐ Other ☐
Contact ✎	

This person received primary eye care at *(location)* ✎ _____ on *(date)* ✎ _____.
The results of the primary eye care screen are outlined below.

General information		
Pre-term or low birth weight baby ☐	Eye pain ☐ Eye discharge ☐ Eye itchiness ☐ Eye injury ☐ Blurred vision ☐	
Diabetes and/or high blood pressure ☐	Wears spectacles ☐	
Currently receives care from eye health professional ☐	Other ✎	
Vision screen		
Fundus reflex *Children 3 years and younger only*		
Healthy reflex both eyes ☐	Unhealthy colour or brightness in one or both eyes ☐	No fundus reflex in one or both eyes ☐
Details ✎		
Distance vision screen *Adults and children over 3 years only*		
Vision tested: With spectacles ☐ Without spectacles ☐		
Right eye: Pass ☐ Did not pass ☐	Left eye: Pass ☐ Did not pass ☐	
Not able to complete distance vision screen ☐	Details ✎	
Near vision screen *Adults 40 years and older only*		
Vision tested: With spectacles ☐ Without spectacles ☐		
Near vision: Pass ☐ Did not pass ☐	Not able to complete near vision screen ☐	
Details ✎		
Eye health screen		
Both eyes look healthy: Yes ☐ No ☐		

Red eye problem	Redness ☐ Watery discharge ☐ Sticky discharge ☐ Eye itchiness ☐
External eye problem	Crust on eyelids/lashes ☐ Eyelashes turn inward ☐ Swelling ☐ Lump/s ☐ Growth/s ☐
Eye injury	Chemical ☐ Burn ☐ Foreign body ☐ Knock or cut ☐
Another eye problem	Pupil or cornea appears unclear/white/milky ☐ Eyes not looking in same direction ☐ Other ☐

Not able to complete eye health screen ☐	
Details ✎	
Pupil reactions and eye movement *People with knock to eye only*	
Pupil reactions pass both eyes: Yes ☐ No ☐	Eye movement pass both eyes: Yes ☐ No ☐
Details ✎	
Actions taken	
Referral only ☐ → Urgent referral ☐	Eye health education provided ☐
Eye washout ☐	Foreign body removed from eye ☐
Eyelashes and eyelids cleaned ☐	Inward turning eyelashes removed ☐
Hot compress ☐	Cold compress ☐
Eye pad provided ☐	Eye shield provided ☐
Near vision spectacles provided ☐ → Power ✎ _____	
Medication provided ☐ Type ✎ _____ Dose ✎ _____ Instructions ✎	Other ✎

Reason for referral	
Details ✎	
Name of screener ✎	Contact details ✎