



Fax to 02 8115 0799

To refer to Centre for Eye Health, you must first register. Registration is free and simply involves completing the following details, reviewing our terms and conditions and returning the signed form. Once registered, you will be sent a referrer information pack. Please print clearly and tick checkboxes as appropriate.

NOTE: If you are already registered with CFEH and wish to change your details, please complete the Practitioner Change of Details form.

REFERRER DETAILS

Title: _____ Profession: _____
First Name: _____ Last Name: _____

I am registering for: [] General Clinic [] Glaucoma Management Clinic [] Both
For Optometrists: [] I am therapeutically qualified [] I am not therapeutically qualified
What has prompted you to register? [] Letter [] Advertisement [] Article [] Colleague/ Patient
[] Email [] Website [] SCOPE/ CPD event [] Other: _____

PRIMARY PRACTICE DETAILS

Note: Locums do not need to complete.

Practice Mailing Address: _____ Practice Name: _____
Preferred Contact Method: [] Phone [] Mobile [] Post [] Email
Suburb: _____ Postcode: _____ State: _____ Practice Street Address (if different): _____ Suburb: _____ Postcode: _____ State: _____
Phone: _____ Email: _____
Medicare Provider Number: _____

SECONDARY PRACTICE DETAILS

Note: Locums do not need to complete.

Practice Mailing Address: _____ Practice Name: _____
Preferred Contact Method: [] Phone [] Mobile [] Post [] Email
Suburb: _____ Postcode: _____ State: _____ Practice Street Address (if different): _____ Suburb: _____ Postcode: _____ State: _____
Phone: _____ Email: _____
Medicare Provider Number: _____

NB. Please photocopy as needed for additional practices

COMMUNICATION FROM CFEH

The Centre will provide important updates, CPD offers and other relevant opportunities to its registered practitioners. To receive this information, please provide your consent and contact details below (if different from practice above).

[] Yes, I would like to receive updates via [] Email or [] Post [] No, I do not want to receive updates
Mailing Address: _____ Mobile: _____
Suburb: _____ Postcode: _____ State: _____ Email: _____

AGREEMENT

I acknowledge that in registering to be a referrer with Centre for Eye Health I agree to abide by the Terms and Conditions.

Signature: _____ Date: []/[]/[]

See our website for Terms and Conditions



Thank you for registering to refer to the Glaucoma Management Clinic (GMC) at Centre for Eye Health (CFEH). We are collecting additional referrer information to help us assess the effectiveness of the GMC and maintain future operations. Please take a few minutes to complete the questions below.

Please fax completed form to 02 8115 0799

1	Please enter your name: _____ Provider number: _____ Practice name: _____
2	If you are therapeutically qualified, do you have a <u>formal glaucoma collaborative care arrangement</u> with a private ophthalmologist? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Informal <input type="checkbox"/> In preparation <input type="checkbox"/> I am not therapeutically qualified
3	Does your practice have the following: <i>(please tick all that apply)</i> <input type="checkbox"/> Fundus camera <input type="checkbox"/> OCT. Please specify model(s) [e.g. Cirrus, Topcon, Nidek]: <input type="checkbox"/> GDx _____ <input type="checkbox"/> Pachymeter <input type="checkbox"/> Perimeter. Please specify model(s) [e.g. Matrix, Medmont]: <input type="checkbox"/> Gonioscopy lens _____
4	Which tonometer(s) do you have? <i>(please tick all that apply)</i> <input type="checkbox"/> iCare <input type="checkbox"/> NCT <input type="checkbox"/> Perkins / Goldmann <input type="checkbox"/> Other. Please specify: <input type="checkbox"/> Tono-Pen _____

Thank you for completing this form. We appreciate your time and support.

If you have any queries please contact us at enquiries@cfeh.com.au



OPTOMETRIST INFORMATION STATEMENT AND CONSENT FORM FOR CFEH RESEARCH AND CLINICAL EFFICIENCY REVIEW

In addition to providing NSW and ACT residents with free access to advanced eye imaging and assessment services, Centre for Eye Health (CFEH) is a valuable resource for research and committed to a stringent clinical efficiency review process. The information we gather from our clients and referrers will enable us to streamline patient referral and management processes. We also provide feedback to funding agencies and research analysts to maintain support for the CFEH and develop strategies for improved patient management. Before we can report information provided by you to third parties, we need your permission.

Confidentiality and Disclosure of Information

Information collected from referral and referral-related forms to CFEH, that can be identified with you or your patient, will remain confidential and will not be disclosed, except as required by law when requested. If you give us your permission by signing this document, we may use the information we have collected from your referral forms to report on clinical management and efficiency in the area of eye health. **Note: In any published material, information will be presented in such a way that you and the referred patient cannot be identified.**

Voluntary Participation and Withdrawal

Giving CFEH permission to use your information for research and reporting purposes is voluntary. You may decide not to give us permission or withdraw your permission at any time without penalty.

Communication of Findings

CFEH will communicate significant findings via the CFEH website, funding agencies, conference presentations and peer reviewed scientific publications.

Complaints

Complaints may be directed to the Ethics Secretariat, The University of New South Wales, Sydney 2052 NSW (phone: 9385 4234, fax: 9385 6648, email: ethics.sec@unsw.edu.au). Any complaint you make will be investigated promptly and you will be informed of the outcome.

Questions

Should you have any questions about research or review processes conducted at CFEH, please feel free to ask us. Michael Yapp, Chief Optometrist (enquiries@cfeh.com.au or 02 8115 0700) will be happy to answer questions.

Permission

Having read the information provided above, please indicate below whether you have decided to allow CFEH to use your information for research and review purposes by signing below.

Declaration by of consent

I have read and understand the information outlined above. I freely give CFEH permission to use the information that I provide on referral and referral-related forms for review and research purposes and understand that I am free to withdraw at any time.

Referrer Signature: _____

Referrer Name: _____

Date: _____