Centre for Eye Health

OPTOMETRIST REFERRAL FORM

Urgent referrals should not be sent to CFEH

FAX to (02) 8115 0799 or enter online at www.cfeh.com.au

Patient contact details

Title: _____

First name: _____

Surname: _____

Date of birth: ____ /____ /_____

Mailing address: _____

Suburb: _____ State:_____ Postcode: _____

Enter language if an Interpreter is required:

_____

Please ensure Patient is eligible for CFEH Services

Does NOT have private Health ☐ and/or

Has NSW Concession Card* ☐ and/or

Is over 60 years old ☐

*Concession Cards: Low Income Health Care Card, Pensioner Card, Commonwealth Seniors Health Card, Veteran Gold Card, Seniors Card, Veteran Gold Card, Disability support, JobSeeker

Phone number: _____

Email: _____

◉ **UNSW KENSINGTON**

○ **CAMERON CENTRE - PARRAMATTA**

Patient clinical details

Refraction and VA: R_____ 6/_____ L_____ 6/_____ Date: ____ /____ /_____

IOP: R_____mmHg L_____ mmHg Method _____

Pertinent exam findings (please attach **imaging and visual fields** if available):

_____

Patient currently under ophtamological care? ○ Yes ○ No ○ Co-Mgmt If Yes, complete below

Ophthalmologist: Condition: Last Consult:

Assessment

(please select one)

- ○ Glaucoma
- ○ Narrow angles
- ○ Macula
- ○ Pigmented lesion
- ○ Peripheral retina
- ○ Corneal ectasia
- ○ Optic nerve
- ○ Diabetic Retinopathy
- ○ High myopia
- ○ Drug toxicity
- ○ Corneal dystrophy (UNSW)
- ○ Other: _____

OR

Management

(please select one)

- ○ Glaucoma
- ○ Narrow angles
- ○ Macula
- ○ Pigmented lesion
- ○ Peripheral retina
- ○ Optic Nerve
- ○ Diabetic Retinopaty
- ○ High myopia
- ○ Drug toxicity
- ○ Retinal dystrophy(UNSW)

See CFEH Terms and Conditions for more information: www.cfeh.com.au

Referring practitioner details

Name:_____ Practice name/branch:_____

Medicare provider number:_____ Signature: _____ Date: ___ /___ /_____

Managing Optometrist (to CC if locum unable to provide follow up on the report)_____