Centre for Eye Health

OPTOMETRIST REFERRAL FORM

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

Patient contact details

Title: ○ Dr ○ Mr ○ Mrs ○ Ms ○ Other: _____

First name: _____

Surname: _____

Date of birth: ____ /____ /_____

Mailing address: _____

_____

Suburb: _____ State: _____ Postcode: _____

Assistance required

Mobility: ☐ Wheelchair: ☐ Other: _____

Hearing interpreter: ○ Yes ○ No

Language interpreter: ○ Yes ○ No

If yes, specify language: _____

Phone number: _____

Email: _____

○ UNSW KENSINGTON ○ SUTHERLAND HOSPITAL

Patient clinical details

Urgent referrals should not be sent to CFEH

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

Reason for referral: _____

Pertinent exam findings (please **attach VF** and describe the **location of lesions** if appropriate):

_____

_____

_____

_____

_____

_____

Is the patient currently under ophthalmological care? ○ Yes ○ No ○ Co-Management If yes, complete below:

Ophthalmologist: _____ Condition treated: _____ Last consult date: ____ /____ /_____

Assessment

(please select one)

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

OR

Management

(please select one)

- ○ Glaucoma
- ○ Narrow angles
- ○ AMD
- ○ Non-proliferative diabetic retinopathy
- ○ Posterior eye complications of high myopia
- ○ Other retinal disease

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)_____