



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

CAMERON CENTRE - PARRAMATTA

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
Other:
Optic nerve
Diabetic Retinopathy
High myopia
Drug toxicity
Retinal dystrophy (UNSW)
Corneal dystrophy (UNSW)

OR

Management

(please select one)

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

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)