Centre for Eye Health LOCUM OPTOMETRIST REFERRAL FORM

Optometrist to FAX to CFEH (02) 8115 0799

Patient Contact Details

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:

First Name: _____

Surname: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

Mailing Address: _____

_____

Suburb: _____

Postcode: _____ State: _____

Phone: _____ (☐ Home or ☐ Work)

Mobile: _____

Email: _____

Assistance Requested

Mobility ☐ Wheelchair ☐ Other: _____

Language Interpreter: ☐ Yes ☐ No

If yes, please specify language: _____

Hearing Interpreter: ☐ Yes ☐ No

Accommodation#: ☐ Yes ☐ No

Transportation#: ☐ Yes ☐ No

#Conditions apply.

Client Appointment Preference (please tick): ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri **AND** ☐ AM **or** ☐ PM

Patient Clinical Details

Note: Urgent Referrals should not be sent to the Centre

Refraction and BCVA (Compulsory): Date: _____ R _____ 6/_____ L _____ 6/_____

Primary reason for referral: _____

Pertinent exam findings: _____

_____

_____

Is the patient currently under ophthalmological care? ☐ Yes ☐ No If yes, complete below

Ophthal Name: _____ Condition Treated: _____ Last Consult Date: _____

Please select EITHER Option 1 OR Option 2

OPTION 1: Imaging and Visual Function Services. Please select up to 5 individual tests.

Posterior Eye

Posterior Eye Photo *(select test):*
☐ Pole ☐ Macula ☐ ONH

Optomap/Retinal Photography:
☐ Central 200º ☐ 5 Fields
☐ Specific Location: _____

☐ B-Scan Ultrasound *(specify)*: _____
_____

☐ HRT3 ONH

OCT *(select type):*
☐ Macula ☐ ON
☐ Other: _____

☐ Autoflourescence

Anterior Eye

☐ Anterior Eye Photo *(specify)*: _____

Confocal Microscopy *(select type):*
☐ Endothelial Cell Count
☐ Other: _____

Corneal Topography *(select type):*
☐ Pentacam HR ☐ Medmont E300

☐ Pentacam *(other):* _____

☐ Anterior OCT *(details)*: _____
_____

☐ *UBM (details)*: _____

Biometry

☐ A-Scan Ultrasound ☐ IRX3
☐ Lenstar ☐ Pachymetry

Tests of Visual Function

Acquired Colour Vision *(select)*:
☐ D-15 ☐ De-Sat D-15 ☐ 100 Hue
☐ Sahlgren's
☐ FDT Matrix ***OR*** ☐ Humphrey VFA
(select)
☐ 24-2 ☐ 30-2 ☐ 10-2/Macula
Other: _____

Electrophysiology *(select type):*
☐ ERG ☐ VEP ☐ EOG
☐ Other: _____
_____
_____
_____

OPTION 2: Ocular Condition Assessment. Please select one (Provide a referral letter if space above is insufficient.)

☐ Pigmented Lesion ☐ Cornea ☐ Diabetic Retinopathy ☐ Glaucoma
☐ Macula ☐ Peripheral Retina (DFE must have already been performed) ☐ Optic Nerve (not glaucoma)
☐ Retinal Dystrophy

Referring Practitioner Details (must be completed)

In signing this referral form, I agree to abide by CFEH Referring Practitioner Terms and Conditions, outlined on the Practitioner Registration Form.

Name: _____ Practice Name: _____

Medicare Provider No: _____ Signature: _____ Date: ☐☐ / ☐☐ / ☐☐☐☐