Centre for Eye Health

FOLLOW-UP REFERRAL FORM

Please indicate your response to Centre for Eye Health's recommendation for your patient below.

☐ Yes I would like CFEH to organise a follow up review with this patient

(tick one option below and check and update patient details)

- ☐ Repeat previous tests performed by CFEH
- ☐ Conduct additional/ different tests (*please specify based on standard referral form*): ____________________

____

Patient Contact Details *(Please adjust if changed)*

Title: ____________________

First Name: ____________________

Surname: ____________________

Date of Birth: __________

Mailing Address: ____________________

____

Suburb: __________

Postcode: __________ State: __________

Phone: ____________________

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

#For clients outside of Sydney. Conditions apply. See separate form for details.

Patient Clinical Details *(Please complete if different from last CFEH consult and attach additional information as required)*

Refraction and BCVA: Date: / / R 6/ L 6/

Pertinent exam findings: ____________________

Special instructions: ____________________

Is the patient currently under ophthalmological care for the condition to be review? ☐ Yes ☐ No

Report Details

Please ensure you have setup your Medinexus account as reports will be delivered electronically

☐ No follow-up review is required as the patient *(tick all that apply)*:

- ☐ Has been referred to an ophthalmologist
- ☐ Is under continuing ophthalmological care/treatment
- ☐ Can be monitored by myself
- ☐ Is no longer a patient of my practice
- ☐ Other (*specify*): ____________________

Referring Practitioner Details *(Please check details and sign)*

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: __ __/__ __/__ __ __ __

Please return to CFEH by FAX on (02) 8115 0799 or call 8115 0777 to discuss.

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