Centre for Eye Health

GLAUCOMA CLINIC INITIAL REFERRAL FORM

Optometrist to COMPLETE and FAX to (02) 8115 0799

Patient Contact Details

Title: _____

First Name: _____

Surname: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

Mailing Address: _____

_____

Suburb: _____

Postcode: _____ State: _____

Phone: ( ) _____ (☐ Home or ☐ Work)

Mobile: _____

Email: _____

Assistance Required

Mobility: ☐ Wheelchair ☐ Other: _____

Language Interpreter: ☐ Yes ☐ No

If yes, please specify language: _____

Hearing Interpreter: ☐ Yes ☐ No

Accommodation#: ☐ Yes ☐ No

Transportation#: ☐ Yes ☐

☐ **Px HAS been previously seen at the Centre** ☐ **Px has NOT been previously seen at the Centre**

Patient Clinical Details	Note: attach additional information, such as history, previous ophthalmology correspondence and/or results, as required **(NOTE: Urgent referrals should not be sent to the Centre)**
Refraction and BCVA	Date / / (R) 6/ (L) 6/
Primary reason for referral:	☐ Px identified by CFEH as needing a glaucoma related assessment by an ophthalmologist ☐ Px under treatment for glaucoma but due to financial constraints elects to be treated at CFEH ☐ Px identified as a glaucoma suspect or newly diagnosed with glaucoma and would like to be managed by myself and CFEH as part of a shared care program
Pertinent Exam / History: (tick box or fill in information as appropriate)	☐ Px already assessed at CFEH within the last 12 months (no further details required) Relevant History_____ _____ _____ IOP OD_____ OS _____(time) ☐ Humphrey Visual Field attached ☐ Other Visual Field attached ☐ OCT attached: Medinexus / Secure Email/ Given to Patient (circle as appropriate)
Has the patient previously been under ophthalmological care?	☐ Yes (complete below) ☐ No
Ophthal Name:	Condition(s) Treated: / Last Consult Date:

Please select EITHER Option 1 or Option 2

☐ **OPTION 1: I would like to be involved in a Shared Care arrangement**

Further details of the individuals shared care plan will follow the assessment with the consultant Ophthalmologist

☐ **OCT and Humphrey VF at the Centre** ☐ **OCT at my practice** ☐ **OCT and Humphrey VF at my practice**

☐ **OPTION 2: I would like the Centre to manage the patient's glaucoma care**

In signing this referral form, I agree to abide by CFEH glaucoma management clinic Referring Practitioner Terms and Conditions including managing all of the patients non-glaucoma related ocular needs

Name _____

Practice Location: _____

_____

Provider No: _____

Signature: _____

Date: _____/_____/_____

Centre for Eye Health - Glaucoma Management Clinic

A POWH Ophthalmology/CFEH Collaboration

General Enquiries: 1300 421 960 or enquiries@cfeh.com.au

Referrer Advice Line: (02) 8115 0777