

GLAUCOMA CLINIC INITIAL REFERRAL FORM

Optometrist to COMPLETE and FAX to (02) 8115 0799

<p>Patient Contact Details</p> <p>Title: _____</p> <p>First Name: _____</p> <p>Surname: _____</p> <p>Date of Birth: <input type="text"/> / <input type="text"/> / <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Mailing Address: _____</p> <p>Suburb: _____</p> <p>Postcode: _____ State: _____</p>	<p>Phone: () _____ (<input type="checkbox"/> Home or <input type="checkbox"/> Work)</p> <p>Mobile: _____</p> <p>Email: _____</p> <p>Assistance Required</p> <p>Mobility: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other: _____</p> <p>Language Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify language: _____</p> <p>Hearing Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Accommodation#: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Transportation#: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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:	<input type="checkbox"/> Px identified by CFEH as needing a glaucoma related assessment by an ophthalmologist <input type="checkbox"/> Px under treatment for glaucoma but due to financial constraints elects to be treated at CFEH <input type="checkbox"/> 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)	<input type="checkbox"/> Px already assessed at CFEH within the last 12 months (no further details required) Relevant History _____ _____ _____ IOP OD _____ OS _____ (time _____) <input type="checkbox"/> Humphrey Visual Field attached <input type="checkbox"/> Other Visual Field attached <input type="checkbox"/> OCT attached: Medinexus / Secure Email/ Given to Patient (circle as appropriate)		
Has the patient previously been under ophthalmological care? <input type="checkbox"/> Yes (complete below) <input type="checkbox"/> No			
Ophthal Name:	Condition(s) Treated:	Last Consult Date:	

Please select EITHER Option 1 or Option 2

<input type="checkbox"/> 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 <input type="checkbox"/> OCT and Humphrey VF at the Centre <input type="checkbox"/> OCT at my practice <input type="checkbox"/> OCT and Humphrey VF at my practice
<input type="checkbox"/> 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: _____ / _____ / _____