



Optometrist to FAX to CFEH (02) 8115 0799

Please print clearly and tick as appropriate.

Patient Contact Details

(NOTE: Urgent referrals should not be sent to the Centre)

Title: _____ Phone: () _____ (Home or Work)
First Name: _____ Mobile: _____
Surname: _____ Email: _____
Date of Birth: / /
Mailing Address: _____
Suburb: _____
Postcode: _____ State: _____
Assistance Required
Mobility: Wheelchair Other:
Language Interpreter: Yes No
If yes, please specify language: _____
Hearing Interpreter: Yes No
Accommodation#: Yes No
Transportation#: Yes No #Conditions apply.

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

PRIMARY REASON FOR REFERRAL

- APPOINTMENT DUE / REPORT FROM SHARED CARE VISIT
- LOCAL OR SYSTEMIC SIDE EFFECTS TO CURRENT GLAUCOMA DROPS
- CHANGE IN DISC APPEARANCE
- PROGRESSIVE FIELD LOSS
- IOP CONSISTANTLY ABOVE TARGET

Patient Clinical Details Attach additional information, such as history, previous ophthalmologist correspondence AND results, as required

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

Reason reduced acuity: _____
(If appropriate)

Current glaucoma medications: _____

Pertinent Exam details / History: _____

IOP OD _____ OS _____ (time / date)
IOP OD _____ OS _____ (time / date)
IOP OD _____ OS _____ (time / date)

Humphrey Visual Field attached Other Visual Field attached
OCT attached: Medinexus / Secure Email/ Given to Patient (circle as appropriate)

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: / /