Centre for Eye Health

GLAUCOMA CLINIC FOLLOW UP REFERRAL FORM

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: _____

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 ☐ 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 correspondance AND results, as required

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

Reason reduced accuity: (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: ☐☐ / ☐☐ / ☐☐☐☐

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