



Practitioner to FAX to CFEH (02) 8115 0799

Patient Contact Details

Title: Dr Mr Mrs Miss Ms Other:

First Name:

Surname:

Date of Birth: []/[]/[]

Mailing Address:

Suburb:

Postcode:

State:

Phone: (Home or Work)

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

#Conditions apply.

Client Appointment Preference (please tick): Mon Tues Wed Thurs Fri AND AM or PM

Patient Clinical Details

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

Primary reason for referral:

Pertinent exam findings:

Imaging and Visual Function Services. Please select up to 5 individual tests.

Posterior Eye

Posterior Eye Photo (select test): Pole Macula ONH

Optomap/Retinal Photography: Central 200 5 Fields

Specific Location:

B-Scan Ultrasound (specify):

HRT3 ONH

OCT (select type):

Macula GCA RNFL / ONH

Angiography

Specific location:

Autofluorescence

Anterior Eye

Anterior Eye Photo (specify):

Anterior OCT (details):

Corneal Topography (select type):

Pentacam HR Medmont E300

Pentacam (other):

Confocal Microscopy (select type):

Endothelial Cell Count

Other:

UBM (details):

Biometry

A-Scan Ultrasound IRX3

Pachymetry

Tests of Visual Function

Acquired Colour Vision (select):

D-15 De-Sat D-15 100 Hue

Sahlgren's

Visual Fields

FDT Matrix OR Humphrey VFA

(select)

24-2 30-2 10-2/Macula

Other:

Electrophysiology (select type):

ERG VEP EOG

Other:

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: []/[]/[]