Centre for Eye Health

OPHTHALMOLOGIST REFERRAL FORM

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: ☐☐ / ☐☐ / ☐☐☐☐