Centre for Eye Health

OPTOMETRIST REFERRAL FORM

FAX to (02) 8115 0799 for UNSW Kensington or Sutherland Hospital

Patient contact details

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Other: ____________

First name: ________________________________

Surname: ________________________________

Date of birth: ____ /____ /_____

Mailing address: ________________________________

____

Suburb: ________________ State: _______ Postcode: _____

Assistance required

Mobility ☐ Wheelchair ☐ Other: _______________

Hearing interpreter ☐ Yes ☐ No

Language interpreter ☐ Yes ☐ No

If yes, specify language: ____________________

Phone (H/W): _____________ Mobile: ______________

Email: ________________________________

Patient clinical details

Urgent referrals should not be sent to CFEH

Refraction and VA: R _______________________ 6/____ L ________________________ 6/____ Date: ____ /____ / ____

Primary reason for referral: ________________________________

Suspected diagnosis: ________________________________

Pertinent exam findings (including the location of any lesions): ________________________________

____

____

Is the patient currently under ophthalmological care? ☐ Yes ☐ No If yes, complete below:

Ophthalmologist: ______________________ Condition treated: __________________ Last consult date: ____ /____ /_____

☐ UNSW KENSINGTON

☐ Option 1 – Imaging and visual function services

Please select up to five individual tests

Posterior eye

Posterior photograph

☐ Pole ☐ Macula ☐ ONH

Optomap

☐ Central 200° ☐ 5 fields ☐ Autofluorescence

Optical coherence tomography (OCT)

☐ Macula ☐ ONH+GCA ☐ Angiography ☐ Other location

☐ B-scan ultrasound ☐ HRT3

Anterior eye

☐ Anterior photograph

☐ Pentacam ☐ Medmont E300

☐ Confocal microscopy ☐ Endothelial cell count

☐ Anterior OCT ☐ Ultrasound biomicroscopy

Biometry

☐ Pachymetry ☐ IRX3 aberrometry ☐ A-scan ultrasound

Visual function

☐ Humphrey VFA or ☐ FDT Matrix

☐ 30-2 ☐ 24-2 ☐ 10-2/Macula ☐ Other: _________

Acquired colour vision

☐ D-15 ☐ De-Sat D-15 ☐ Sahlgren's ☐ 100 Hue

Electrophysiology

☐ ERG ☐ VEP ☐ EOG ☐ Other: ________________

☐ Option 2 – Ocular condition assessment

Please select one

☐ Glaucoma ☐ Optic nerve ☐ Macula

☐ Pigmented lesion ☐ High myopia* ☐ Cornea

☐ Peripheral retina* ☐ Retinal dystrophy* ☐ Diabetes*

☐ SUTHERLAND HOSPITAL

☐ Option 1 – Imaging and visual function services

Please select up to five individual tests

Posterior eye

Posterior photograph

☐ Pole ☐ Macula ☐ ONH

Optomap

☐ Central 200° ☐ 5 fields ☐ Autofluorescence

Optical coherence tomography (OCT)

☐ Macula ☐ ONH+GCA ☐ Angiography ☐ Other location

Anterior eye

☐ Anterior photograph

☐ Medmont E300

☐ Anterior OCT

Biometry

☐ Pachymetry ☐ Lenstar ☐ A-scan ultrasound

Visual function

☐ Humphrey VFA

☐ 30-2 ☐ 24-2 ☐ 10-2/Macula ☐ Other: _________

Acquired colour vision

☐ D-15 ☐ De-Sat D-15 ☐ 100 Hue

☐ Option 2 – Ocular condition assessment

Please select one

☐ Glaucoma ☐ Optic nerve ☐ Macula

☐ Pigmented lesion ☐ High myopia* ☐ Diabetes*

☐ Peripheral retina* *DFE must have already been performed

Referring practitioner details

In signing this referral form I agree to abide by CFEH Referring Practitioner Terms and Conditions outlined on the website.

Name: ________________________ Practice name/branch: ________________________

Medicare provider number: ____________________ Signature: ____________________ Date: ____ /____ / ____