Centre for Eye Health

COLLABORATIVE CARE GLAUCOMA REFERRAL

FAX to (02) 8115 0799 for GLAUCOMA MANAGEMENT at UNSW Kensington

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: ____

Reason for Referral

***Please note**: This clinic is <u>not suitable</u> for patients with prior glaucoma surgery, angle closure, advanced glaucoma (i.e. visual field defects within 10 degrees of fixation or mean deviation of worse than -12dB) and monocular patients.*

☐ **High-risk glaucoma suspect who likely requires treatment.** For other suspects, please refer to CFEH general clinic for testing.

☐ **On treatment for glaucoma but wishes to transfer to CFEH.** Reason: ____

Please attach most recent letters/correspondence.

Diagnosis: ____

Previous treatment:______________________________

Pre-treatment IOP: R_____ L_____ Method: _____________

Patient Clinical Details

****Please ensure details are <u>complete</u> as missing data may delay patient care***

Refraction and VA*: R ______________________ 6/____ L ______________________ 6/____ Date: ____ /____ / ____

IOP*: R __________ L __________ (Time: ________) **Method**: ☐ Applanation ☐ Other ______________________________

Angle status*: R ___________ L _____________ **Method**: ☐ Gonioscopy ☐ Van Herick ☐ Other _______________

Optic nerve observations*:____ ☐ Disc haemorrhage

☐ **Copy of visual field is attached*** VF observations: ____

Risk Factors: ☐ Family history (sibling/parent) ☐ Pseudoexfoliation/Pigment Dispersion ☐ Other ____________________

Other relevant information:____

Shared Care Arrangement *(Please select one option)*

☐ I am therapeutically-endorsed, have access to OCT & Humphrey VF (not FDT Matrix) and wish to be involved in shared care.

☐ I would like CFEH to manage the patient's glaucoma.

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: ____ /____ / ____