Centre for Eye Health

OPTOMETRIST REFERRAL FORM

FAX to (02) 8115 0799 or email to enquiries@cfeh.com.au 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 (5 field assessment available as Option 2)
☐ Central 200° ☐ 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 (5 field assessment available as option 2)
☐ Central 200° ☐ 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: ____ /____ / ____