Centre for Eye Health

OPTOMETRIST REFERRAL FORM

Optometrist to FAX to CFEH (02) 8115 0799

Please print clearly and tick as appropriate.

Patient Contact Details

Title: ____________________
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 Note: attach additional information, such as history and/or results, as required.

Primary reason for referral: ____________________
Diagnosed/ suspected condition: ____________________
Refraction and BCVA: Date: / / R 6/ L 6/
Pertinent exam findings: ____________________
Special instructions: ____________________
Is the patient currently under ophthalmological care? ☐ Yes ☐ No If so, please attach details.

REQUESTED SERVICE

Please select either ☐ OPTION 1 or ☐ OPTION 2 below.
Note: Either option may involve consultation with a CFEH ophthalmologist, as required.

☐ OPTION 1: Imaging and Visual Function Services. Please select up to 3 individual tests.

Photography
☐ Anterior Eye *(specify)*: __________
☐ Posterior Eye *(circle tests)*
| Pole | Macula | ONH |
☐ Peripheral lesion R / L *(circle location)*
| S | SN | N | IN | I | IT | T | ST |
☐ Ultra-Widefield Photography *(Optomap)*

Posterior Eye
☐ B-Scan Ultrasound *(specify)*: __________
☐ GDx PRO
☐ HRT3 ONH
☐ OCT *(select)*
[ ] *Macula* [ ] *ONH*
[ ] *Other:* __________

Anterior Eye
☐ Confocal Microscopy *(select type)*
[ ] *Endothelial Cell Count*
[ ] *Other:* __________
☐ Corneal Topography *(select type)*
[ ] *Pentacam HR* [ ] *Medmont E300*
☐ Pentacam *(specify)*: __________
☐ OCT *(select)* ☐ UBM
[ ] *Cornea*
[ ] *Anterior Segment (circle location)*
| S | SN | N | IN | I | IT | T | ST |

Biometry
☐ A-Scan Ultrasound ☐ IRX3
☐ Lenstar ☐ Pachymetry

Tests of Visual Function
☐ Acquired Colour Vision *(circle tests)*
| D-15 | De-Sat D-15 | 100 Hue
| Sahlgren's |
☐ FDT Matrix ***OR*** ☐ Humphrey VFA
(select type)
[ ] *24-2/30-2* [ ] *10-2/Macula*
[ ] *Other:* __________
☐ Electrophysiology *(select type)*
[ ] *ERG* [ ] *VEP* [ ] *EOG*
[ ] *Other:*
☐ Psychophysics *(specify)*: __________
____

☐ OPTION 2: Ocular Condition Assessment. Please select one (Provide a referral letter if space above is insufficient.)

☐ Central Retina ☐ Cornea ☐ Diabetic Retinopathy ☐ Glaucoma
☐ Macula ☐ Peripheral Retina ☐ Optic Nerve ☐ Retinal Dystrophy

Report Details

Please send a second copy of the results ☐ Yes ☐ No
I would like to receive these results as a ☐ Hard Copy or on ☐ CD

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: [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

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