



Referring Practitioner FAX to CFEH (02) 8115 0799

Please print clearly and tick as appropriate

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, 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 \_\_\_\_/\_\_\_\_ L \_\_\_\_/\_\_\_\_
Pertinent exam findings: \_\_\_\_\_
Special instructions: \_\_\_\_\_

Imaging and Visual Function Services: Select up to 3 individual tests

Photography
[ ] Anterior Eye (specify): \_\_\_\_\_
[ ] Posterior (circle test) | Pole | Macula | ONH |
[ ] Peripheral retinal 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 type) [ ] 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 type) [ ] Cornea [ ] Anterior Segment (circle location) | S | SN | N | IN | I | IT | T | ST |
[ ] UBM
Biometry
[ ] A-Scan Ultrasound [ ] IRX3
[ ] Lenstar [ ] Pachymetry
Tests of Visual Function and System
[ ] Acquired Colour Vision (circle test) | 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 (from January 2011): \_\_\_\_\_

Report Details Please send a second copy of the results [ ] Yes [ ] No
I would like to receive the report 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: \_\_\_\_/\_\_\_\_/\_\_\_\_