



Optometrist to FAX to CFEH (02) 81 15 0799

Please print clearly and tick as appropriate.

Patient Contact Details

Title: _____ Phone: () _____ (Home or Work)
First Name: _____ Mobile: _____
Surname: _____ Email: _____
Date of Birth: / /
Mailing Address: _____
Suburb: _____
Postcode: _____ State: _____
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
Tests of Visual Function
Posterior Eye
Biometry

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: / /