LOW VISION REFERRAL FORM

Centre for Eye Health
The Cameron Centre, 99 Phillip Street
Parramatta NSW 2150

FAX to (02) 8115 0799 OR enter at www.cfeh.com.au OR send through Oculo

Patient contact details

Title: ◯ Dr ◯ Mr ◯ Mrs ◯ Ms ◯ Other: _____

First name: _____

Surname: _____

Date of birth: ____ /____ /_____

Mailing address: _____

_____

Suburb: _____ State: _____ Postcode: _____

Phone number: _____

Email: _____

Assistance requirements

Mobility: ☐ Wheelchair ☐ Other: _____

Hearing interpreter: ◯ Yes ◯ No

Language interpreter: ◯ Yes ◯ No

If yes, specify language: _____

Reason(s) for referral *i.e. difficulties experienced due to vision loss*

_____

_____

_____

_____

_____

Patient clinical details

Refraction and VA: R _____ 6/____ L _____ 6/____ Date: ____ /____ / _____

Relevant ocular and medical history:

_____

_____

_____

_____

Attachments*

☐ Additional history/reports ☐ Visual fields ☐ OCT ☐ Retinal photos

☐ Other: _____

**Please attach where possible to assist with developing an individualised rehabilitation program*

Referring practitioner details

Name: _____ Practice name/branch: _____

Medicare provider number: _____ Signature: _____ Date: ___ /___ /_____