Centre for Eye Health

OPHTHALMOLOGIST REFERRAL FORM

Practitioner to FAX to CFEH (02) 8115 0799

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, 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

Refraction and BCVA: Date: __________ R __________ 6/ ______ L __________ 6/

Primary reason for referral: ______________________

Pertinent exam findings: ______________________

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Imaging and Visual Function Services. Please select up to 5 individual tests.

Posterior Eye

Posterior Eye Photo *(select test)*:

☐ Pole ☐ Macula ☐ ONH

Optomap/Retinal Photography:

☐ Central 200° ☐ 5 Fields

☐ Specific Location: __________

☐ B-Scan Ultrasound *(specify)*: __________

____

☐ OCT *(select type)*:

☐ Macula ☐ GCA ☐ RNFL / ONH

☐ Angiography

☐ Specific location: __________

☐ Autofluorescence

Anterior Eye

☐ Anterior Eye Photo *(specify)*: __________

☐ Anterior OCT (*details*): __________

____

Corneal Topography (*select type*):

☐ Pentacam HR ☐ Medmont E300

☐ Pentacam *(other)*: __________

Confocal Microscopy (*select*

☐ Endothelial Cell Count

☐ Other: __________

☐ UBM *(details)*: __________

Biometry

☐ A-Scan ☐ IRX3

☐ Ultrasound

Tests of Visual Function

Acquired Colour Vision *(select)*:

☐ D-15 ☐ De-Sat D-15 ☐ 100 Hue

☐ Sahlgren'

Visual Fields

☐ FDT Matrix ***OR*** ☐ Humphrey VFA

(select)

☐ 24-2 ☐ 30-2 ☐ 10-2/Macula

Other: __________

Electrophysiology *(select type)*:

☐ ERG ☐ VEP ☐ EOG

☐ Other: __________

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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: __ __ / __ __ / __ __ __ __