Referral Form

Medicare No. ....

Name: .... Date of Birth: ....

Address: .... Postcode: ....

Telephone: .... Email: ....

Secondary contact (if applicable)

Name: .... Relationship: .... Telephone: ....

Ocular and Related Medical Condition

Diagnosis: ....

Prognosis   Stable ☐   Progressive ☐

Onset: ....

Current Medications: ....

....

Other Relevant Medical Conditions: ....

....

Current Visual Status (details of recent refraction within preceding 6 months)

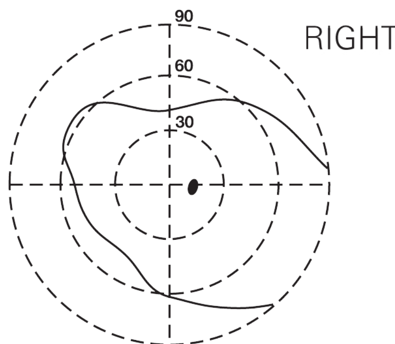
Current Glasses

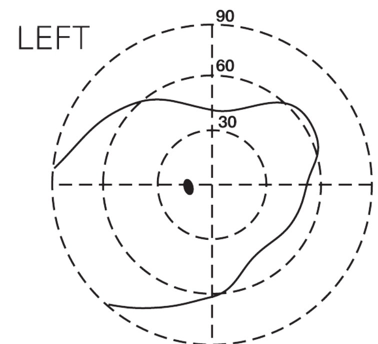
	Glasses Prescription	Visual Acuity
RE		
LE		
Near Add		

Best Correct Vision / Refraction

	Refraction	Visual Acuity
RE		
LE		
Near Add		

Indicate any visual field defect **(if significant defect please enclose computerised field).**





Comments ....

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....

....

Please either stamp or print Practitioner's name and address in full.

....

....

....

Signed: ....

Date: ....

OFFICE USE

Appt Date ..../......../......... Time ....

1st Contact ..../......../......... DVA ☐

2nd Contact ..../......../.........

Letter Sent ..../......../.........

Reason non attendance

☐ Illness ☐ Did not wish to attend

☐ Contact Later ..../........./........

☐ Distance ☐ Transport

Suite 2, 47 Bolton Street, Newcastle, NSW, 2300

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