



PATIENT REFERRAL FORM

For optometrists, ophthalmologists, GPs & allied health providers

URGENCY

☐ Routine ☐ Soon (2–4wks) ☐ Urgent ☐ Same-day

PREFERRED OPTOMETRIST (OPTIONAL)

☐ Philip Cheng ☐ Jessica Atme ☐ Loretta Li

REASON FOR REFERRAL / SERVICES REQUESTED

- ☐ Myopia assessment & management
- ☐ Orthokeratology (OrthoK) assessment
- ☐ Dry eye assessment & management
- ☐ Complex / specialty CL fitting (RGP, hybrid, scleral)
- ☐ Keratoconus screening & monitoring
- ☐ Other: _____
- ☐ OCT, Optos or other diagnostic imaging
- ☐ Children's vision assessment & family eye care
- ☐ Co-management to optimise patient care
- ☐ Same-day ocular emergency
- ☐ Comprehensive eye health check exam

PATIENT DETAILS

PATIENT FULL NAME

PARENT / GUARDIAN — if child

ADDRESS

DATE OF BIRTH

PHONE NUMBER

EMAIL

CLINICAL INFORMATION

REASON/S FOR REFERRAL

BRIEF PATIENT HISTORY

CURRENT OR PREVIOUS TREATMENTS

CURRENT REFRACTION & VISUAL ACUITY

	SPHERE	CYL	AXIS	VA	ADD
R					
L					

REFERRING PRACTITIONER DETAILS

PRACTITIONER NAME

PROVIDER NO.

PRACTICE / CLINIC NAME

PHONE

EMAIL

Practice stamp
(if available)

SIGNATURE

DATE