Referral Template

Demographic Data
Consent given by the patient or guardian

Patient Details

Title: **First Name:** **Surname:**

D.O.B: **Mobile:**

Street Address

Suburb **State** **Postcode**

Medical History

Reasons for referral *(You can select more than one option.)*

- ○ Assistance with Activities of Daily Living e.g. reading, cooking, dressing, grooming etc
- ○ Assistance with Mobility
- ○ Quality of Life and Social Support
- ○ Mental Well-being
- ○ Change in Vision
- ○ Magnification Devices
- ○ Technology Support
- ○ New Diagnosis of Progressive Eye Condition
- ○ School/Employment
- ○ NDIS/MAC Support
- ○ Explore New Services
- ○ Other (Please Specify)

Primary Eye Condition

Other Eye Conditions

Visual Acuities

Refraction

Visual Field Loss ○ Yes or ○ No

Referee Details

Title: **Profession:** **First Name:** **Surname:**

Email: **Phone:**

Street Address:

Suburb: **State:** **Postcode:**