



REFERRAL FORM

For immediate referral phone 4053 7877 and choose Option 2

DATE OF REFERRAL: / /

Referred to: [] Dr Stephen O'Hagan

PATIENT INFORMATION

Name:

Phone Number: (H) (M) (Bus.)

Date of Birth: / / Gender: [] Male [] Female

REFERRAL FOR:

- Cataract, Glaucoma, Pterygium, Diabetic Retinopathy, Wet ARMD, Dry ARMD, Retinal Vein Occlusion, Retinal Disease (ERM / VMT), Other

Details:

Vision without glasses: R 6/ L 6/

Refraction: R L 6/ 6/

Relevant Hx / Findings / Diagnosis:

REFERRING PRACTITIONER:

Name: Provider Number:

Practice:

Telephone Number:

Signature:

