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Optometric Referral – Dry Eye and Co-management

DETAILS OF PATIENT BEING REFERRED

Name: _____

Date of birth _____

REASON FOR REFERRAL

- Dry eye assessment - Oculus K5
- Dry eye treatment - Lipiflow
- Dry eye treatment - IPL and Meibomian gland expression

REFERRAL DATE _____

- Glaucoma co-management
- Therapeutic contact lens fitting
- Other _____

(please enter any relevant clinical notes on the reverse side of this form, or go to the Health Professionals page on our website at www.collinsoptometrists.com.au/pro)

DETAILS OF REFERRING OPHTHALMOLOGIST (OR PRACTICE STAMP)

Name: _____ Phone: _____

Practice name: _____

