COLLINS STREET OPTOMETRISTS

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Intra-optometric Referral

DETAILS OF PATIENT BEING REFERRED

Name: _____ Date of birth _____

REASON FOR REFERRAL **REFERRAL DATE** _____

- ❒ Dry eye assessment and/or management
- ❒ OCT imaging
- ❒ Corneal topography
- ❒ Assessment for drug-induced toxicity
- ❒ Myopia control
- ❒ Glaucoma workup
- ❒ 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/referral-form)

DETAILS OF REFERRING PRACTITIONER (OR PRACTICE STAMP)

Name: _____ Phone: _____

Practice name: _____