SPECIALIST EYE CENTRE

REFERRAL

Patient Name: Date:

Address: DOB:

Phone Number:

REASON FOR REFERRAL

- ☐ Decreased Vision
- ☐ Foreign Body
- ☐ Diabetic r/v
- ☐ Lacrimal/watering
- ☐ Medical Retina
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Plaquenil r/v
- ☐ Refractive Surgery
- ☐ Surgical Retina
- ☐ Pterygium
- ☐ Visual Field
- ☐ Eyelid
- ☐ Corneal/Ocular Surface

Other:

REFERRING OPTOMETRIST/DOCTOR

Name: Provider Number:

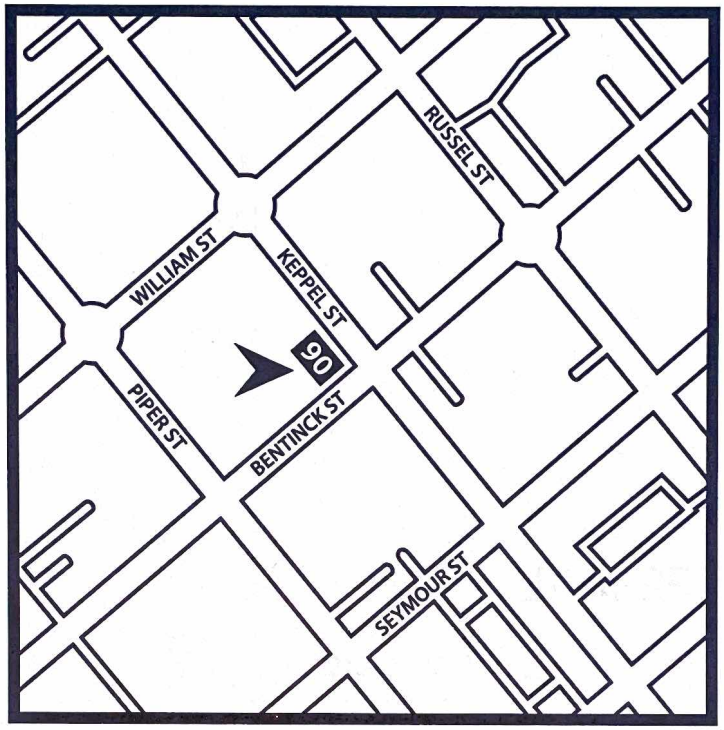
Address: Telephone:

Signed:

Rooms in Lithgow & Bathurst (See Over)
All Appointments: **Tel.** 02 6331 3989 **Fax.** 02 6332 1106
specialisteyecentre.com.au

BATHURST

Specialist Eye Centre
Suite 1, 90 Keppel Street



LITHGOW

Lithgow Specialist Medical Centre
Col Drewe Drive, Sth Bowenfels