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A Suite 2, Kenmore Building, Mater Hospital
Ward Street, Rockhampton QLD 4700
P PO Box 8415, Allenstown QLD 4700

ROCKHAMPTON EYE CLINIC

Date of Referral:_____

Dear Dr._____

Patient Information:

Name:_____

Postal Address:_____

_____

_____

DOB: _____

Phone (H)_____ (M) _____

Email: _____

Please assess this patient regards to:

- ☐ Cataracts
- ☐ Diabetes
- ☐ Continued Care
- ☐ Pterygium
- ☐ Anterior Segment
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Capsular Opacification
- ☐ Lid Anomaly
- ☐ Other _____

Relevant Details:

Refraction: R)_____ L)_____

VA: R)_____ PH _____ L)_____ PH _____

IOP: R)_____ L) _____ at _____ am/pm on_____

Perimetry/Photographs/Other Investigations:

☐ Attached ☐ Emailed ☐ Faxed

Other Details:_____

_____

_____

_____

_____

_____

_____

Referring Optometrist:

Optometrist Name:_____ Provider No._____

Location:_____

Signed:_____

PLEASE ENSURE ALL PATIENT DETAILS ARE CORRECT AS WE USE THIS INFORMATION TO BOOK APPOINTMENTS