UNSW OPTOMETRY CLINIC

UNSW DRY EYE CLINIC REFERRAL FORM

PLEASE FAX TO 02 9313 8604

Please complete this form if you wish to refer a patient to the UNSW Dry Eye Clinic and fax to us. Upon receipt, we will contact your patient to arrange an appointment. Please note that the UNSW Dry Eye Clinic operates on Thursdays between 1.00pm – 4.00pm.

Date: _____

Referring clinician: _____ Provider #_____

Practice address and phone number: _____

Patient first name: _____ Patient surname: _____

Patient date of birth: _____

Patient address: _____

Patient phone number: _____

Date of last full eye exam: _____

Refraction: OD _____ VA: _____ OS _____ VA: _____

Does the patient have signs of dry eye?

- ☐ Yes – please specify _____
- ☐ No

Does the patient have symptoms of dry eye?

- ☐ Yes – please specify _____
- ☐ No

Reason for referral to the UNSW Dry Eye Clinic:

- ☐ Diagnosis only
- ☐ Diagnosis and management
- ☐ Ongoing management for dry eye
- ☐ Specific tests (please specify): _____

Relevant clinical findings: _____

Relevant history: _____

Clinician signature: _____