

## Patient Referral

Name \_\_\_\_\_

D.O.B \_\_\_\_\_

Phone \_\_\_\_\_

### Reason for referral

- |                                    |  |  |
|------------------------------------|--|--|
| <input type="checkbox"/> Cataract  | <input type="checkbox"/> Ocular<br>Surface Tumour        | <input type="checkbox"/> Dry Eye Clinic        |
| <input type="checkbox"/> Pterygium | <input type="checkbox"/> Keratoconus<br>Care Clinic      | <input type="checkbox"/> Refractive<br>Surgery |
| <input type="checkbox"/> Cornea    | <input type="checkbox"/> Other (please specify)<br>_____ |  |

History \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Refraction R \_\_\_\_\_ L \_\_\_\_\_

## Referring Practitioner

Provider No: \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_

**Dr Andrew Apel**  
*MB BS (Qld) FRANZCO  
Fellowship University  
of Toronto  
Corneal Surgery and  
External Eye Disease  
Ophthalmologist*

**Dr John Hogden**  
*MB BS (UNSW)  
BMedSc FRANZCO  
Fellowship University of  
British Columbia (UBC)  
Corneal, Anterior  
Segment and  
Refractive Surgeon  
Ophthalmologist*