

PATIENT REFERRAL FORM

(Please ensure all sections are completed to avoid a delay in patient testing)

1. PATIENT DETAILS – Must be completed

Family Name:

Given Name:

Preferred Name:

Date of Birth:

Sex at Birth: ☐ Male ☐ Female

Medicare Number:

Pension/ Concession Number:

Number on Card:

Expiry:

DVA Card Number:

Address:

DVA Card Color: ☐ Gold ☐ White

Suburb/ City:

State/ Postcode:

Phone (mobile/ home)

Email Address:

Emergency Contact Name/ Number:

Relationship:

Interpreter Required? ☐ Yes – Language:

2. PARENT / GUARDIAN DETAILS — complete this section if the patient is under 18 years of age

Parent/ Guardian 1

Full Name:

Relationship:

Phone Number:

Email:

Parent/ Guardian 2 (Optional)

Full Name:

Relationship:

Phone:

Email:

Additional Notes for Paediatric Assessment

Communication Needs/ Behavioural Considerations:

3. REFERRING PRACTITIONER – Must be completed

Referring Doctor Name:

Specialty:

Address:

Provider Number:

Email:

Phone:

Date of Referral

4. REASON FOR REFERRAL – Must be completed

Primary Indication – tick all that apply

- | | | |
|---|--|---|
| ☐ Generalised Retinal Disorder | ☐ Unexplained Vision Loss | ☐ Birdshot Chorioretinopathy |
| ☐ Macular Dysfunction | ☐ Unexplained Visual Field Loss | ☐ Optic Neuropathy |
| ☐ Bests or Adult Vitelliform | ☐ Hydroxychloroquine Screening | ☐ Albinism |
| ☐ Nystagmus for investigation | ☐ Pre-operative visual function | ☐ Other – Please specify |

Clinical question/ Reason for referral (helps us prioritise and select the correct testing protocol):

5. RELEVANT CLINICAL HISTORY – Must be completed

- The affected eye is: ☐ Right Eye ☐ Left Eye ☐ Both Eyes
- Visual Acuity: Right Left Corrected/ Uncorrected (circle)
- History of Seizures/ Epilepsy: ☐ Yes ☐ No
- Any Contraindications for dilation: ☐ Yes ☐ No

Please provide any additional relevant clinical information:

Additional Documentation Attached: ☐ MRI Reports ☐ Visual Fields ☐ Genetic Results ☐ Clinic Letter

FOR AODI OFFICE USE ONLY —

Date Received:	Received by (name):	VIP Patient Record Number:	
Triaging – Tests required:	Triage Category: ☐ P1 ☐ P2 ☐ P3 ☐ P4	Triaged by:	Triage Date:
Flags: ☐ Baby/ Infant ☐ Seizures ☐ Developmental Delay ☐ Mobility/ Falls Risk ☐ Interpreter Needed ☐ Autism/ Behavioural issues ☐ Other: _____			
Number of Technicians needed: ☐ One ☐ Two			
Patient Added to Waitlist: ☐ Y ☐ N	Referral receipt sent to referring doctor: ☐ Y ☐ N	Patient advised they are on waitlist: ☐ Y ☐ N	
PHRAT/ FRAT sent to patient/ guardian: ☐ Y ☐ N	Questionnaire Sent to patient/ guardian: ☐ Y ☐ N	Quote sent to patient: ☐ Y ☐ N	