HARLEY EYE CLINIC

REFERRAL FORM

- ☐ CATARACT
- ☐ DIABETES
- ☐ MEDICAL RETINA
- ☐ GLAUCOMA
- ☐ PTERYGIUM
- ☐ LASER
- ☐ OTHER

PATIENT DETAILS:

Name: _____ DOB: _____

Address: _____

This patient is referred to;

- ☐ Dr. Michael E. Hammerton
- ☐ Dr. Richard Fleming.
- ☐ Prof. Robert Casson
- ☐ A/Prof Michelle T Sun

FOR ASSESSMENT OF:

CLINICAL DETAILS

REFRACTION:

RIGHT:

LEFT:

REFERRED BY:

NAME: _____

ADDRESS: _____

PROVIDER NO: _____

SIGNATURE: _____ DATE ____/____/____

PLEASE ENSURE THAT THIS REFERRAL LETTER IS POSTED, FAXED, OR EMAILED PRIOR TO THE PATIENT'S APPOINTMENT, ALTERNATIVELY THE PATIENT CAN BRING IT WITH THEM ON THE DAY.

IMPORTANT INFORMATION FOR THE PATIENT

What to expect at your appointment;

- Allow approx. 1 hour for your appointment
- Bring your glasses and this referral
- Bring your Medicare card, Pension card, DVA gold card and Private Health card
- Drops are usually administered resulting in blurred vision therefore, it is recommended that you bring a driver

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Level 2, 195 Melbourne Street
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GLENELG
688-692 Anzac Hwy
GLENELG SA 5045
Ph: 08 8294 7900
Fax: 08 8376 1991

VICTOR HARBOR
11 Torrens Street
VICTOR HARBOR SA 5211
Ph: 08 8267 6544
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