Statewide Vision Resource Centre

Referral Form to East Melbourne Optometry & Low Vision Centre

Is this a FIRST VISIT or REVIEW? - (Circle which is applicable)

FULL NAME:	
ADDRESS:	**POSTCODE:**
TELEPHONE NUMBER:	**DOB:**

OCULAR DIAGNOSIS:

MOST RECENT DISTANCE VISUAL ACUITY (Include date of testing)		
R:	**L:**	**BEO:**
Tested by:		**Date:**

PRINT SIZE (Include Date of Testing)	
Minimum:	**Sustained:**
Tested By:	**Date:**

REASON FOR REFERRAL: eg difficulties accessing print, reference material, reading the whiteboard, computer

Physical considerations:
Special testing requested:
Previous referral to other agencies:
Special considerations:

Visiting Teacher:	DATE:
Referrals Coordinator:	DATE:

Please return this form to:
Marion Blazé
Statewide Vision Resource Centre
PO BOX 201, Nunawading 3131
Phone: (03) 9841 0242 Fax: (03) 9841 0878

Statewide Vision Resource Centre

Authorisation Form)

FULL NAME:	
ADDRESS:	POSTCODE:
TELEPHONE NUMBER:	DOB:
DATE OF LAST VISIT TO EYE SPECIALIST:	

PARENTS' PERMISSION TO RELEASE MEDICAL INFORMATION:

I AGREE that information from my child's clinical case records be supplied by:

NAME OF EYE SPECIALIST:
ADDRESS:
TELEPHONE NUMBER:
HOSPITAL RECORD U.R. NUMBER:

and then forwarded to the East Melbourne Optometry & Low Vision Centre
Suite 214, 100 Victoria Parade
East Melbourne 3002 Tel. 9654 1331

I further AGREE that information from my child's clinical case records be supplied under the terms of the Freedom of Information Act by The East Melbourne Optometry & Low Vision Centre and forwarded to The Statewide Vision Resource Centre, relevant ophthalmologist/optometrist, and/or GP.

Parent's Signature:	Date:
Visiting Teacher:	Date:
Referrals Coordinator:	Date:

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