Statewide Vision Resource Centre

Low Vision Clinic Referral Form (First & Subsequent Visits)

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 print size, reference material reading the blackboard or whiteboard

Physical considerations:
Special testing requested:
Other services requested of the low vision clinic (o.t. etc.)
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

Low Vision Clinic - Authorisation Form (First Visit)

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 LOW VISION CLINIC
446 GLENFERRIE ROAD
KOOYONG 3144

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 Low Vision Clinic and forwarded to The Statewide Vision Resource Centre.

Parent's Signature:	Date:
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