Laser Vision SA

Dr Graham Fraenkel

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Referral Details

Referring Optometrist's Name

Provider No.

Address

Patient Details

Name DOB 07/10/2019

Home Phone **Mobile**

Email

Reason for Referral

☐ Cataracts ☐ Refractive Surgery ☐ PCO

Clinical Notes

Past Ocular History

☐ Amblyopia ☐ Keratoconus ☐ Vision Correction ☐ Retinal

☐ Other

Spectacle / Contact lens script *(please circle)*

R				BCVA	L				BCVA
	/		X			/		X	

Stable for 12 months? Yes ☐ No ☐

Signature _____ Date

Important information for the Patient

For your appointment:

- Allow around 1 ½ hours
- Eye drops may mean you don't want to drive for 2 hours afterwards
- Bring with you your
  - Glasses – reading, distance & sunglasses
  - This referral
  - Cards – Medicare, aged pension, seniors & private hospital
  - Completed questionnaires *(you should receive these by mail)*

White – Ophthal Yellow – GP copy Blue – File copy