Dear Dr KL Lee, thank you for seeing:

Patient Details

Name: _____

Date of birth: _____

Phone: _____

Clinical Information

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Ophthalmology Referral

Reason for Referral

☐ Blurred Vision

☐ Distortion

☐ Flashers/Floaters

☐ AMD

☐ Diabetic Retinopathy

☐ Retinal Vascular Occlusion

☐ Central Serous Chorioretinopathy

☐ Cataract

☐ Epiretinal Membrane

☐ Macular Hole

☐ PVD

☐ Retinal Tear/Detachment

☐ Vitreous Haemorrhage

☐ _____

Referring Doctor/Optometrist

Name: _____

Provider no: _____

Address: _____

Phone: _____

Signature: _____ Date: _____

Please call Dr KL Lee's nearest clinic for an appointment, fax/email this referral to the clinic and bring it with you on the day of the appointment.

For Maitland and Singleton Eye Centre referrals: Fax no 02 4933 5744

For Raymond Terrace rooms referrals: Fax no 02 4926 2012

Email referrals can be sent to: practice@eyecentre.net.au