ophthalmic associates

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☐ **Dr. KL Lee**
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Ophthalmic Surgeon, Vitreoretinal Specialist
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☐ **Dr. Robert Griffits**
MBBS (Hons), FRANZCO
Ophthalmic Surgeon

☐ **Dr.**

Patient

Name .....

Date of Birth ..... Contact Number .....

Reason for Referral

☐ Cataract
☐ Wet / Dry AMD
☐ Flashes / Floaters
☐ Distortion
☐ Diabetic Retinopathy
☐ Glaucoma
☐ Optic Disc Swelling
☐ Retina Tear / Detachment
☐ Macular Oedema
☐ Other

Visual Acuity

R Eye ..... L Eye .....

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Referring Doctor / Optometrist

Name ..... Date .....

Address ..... Signature .....

.....

Telephone ..... Provider No .....

* Please fill in contact details for correspondence.