OPTOMETRIST AND GP REFERRALS

Date: ……

PATIENT DETAILS:

Salutation: Mr / Mrs / Ms / Mx / Master

First Name: ……

Surname: ……..……...

Contact Number: ……

Email: ……..……

REFERRAL STATUS:

☐ Urgent Referral ☐ Non-Urgent Referral

REASON FOR REFERRAL

☐ Cataract ☐ Cornea Disease ☐ Refractive Surgery

☐ Dry Eye ☐ Other

Phone: +61 7 3849 1511 | **Email:** info@drcameronmclintock.com.au |

DETAILS OF REFERRAL:

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LOCATION FOR REFERRAL

☐ Southside Eye Centre – Upper Mount Gravatt

☐ Queensland Laser Vision – Spring Hill

☐ Mary River Eye Specialists – Hervey Bay

☐ Westside Eye Doctors - Taringa

REFERRER DETAILS

Name: ……

Clinic: ……

Contact Number: ……

Email: ……

Please email the referral to info@drcameronmclintock.com.au
or alternatively fax to +61 7 3849 1116