QUT Health Clinics
ABN 83 791 724 622

Queensland University of Technology

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QUT HEALTH CLINICS – OPTOMETRY MYOPIA CLINIC REFERRAL FORM

Date Referring Clinic/Practice

REFERRER DETAILS

Name Electronic Signature

Address Provider No.

Phone Fax Email

Preferred report delivery: ☐ Fax ☐ Mail ☐ Email (password protected file)

PATIENT CONTACT DETAILS

Title Surname Given Name

Address

Phone (H) (M) (W)

Email

Date of Birth New patient to QUT Health Clinics ☐ Yes ☐ No

RELEVANT HISTORY AND CLINICAL INFORMATION

Family myopia history

Previous spectacle prescription/s (with dates if available)

Previous/current myopia control treatment

Cycloplegic refraction and vision

R _____ (6 /) L _____ (6 /)

Binocular vision assessment

Phoria D _____ N _____

MEM R _____ L _____

Other _____

OTHER FINDINGS

Contact QHC Reception directly for current pricing and speciality services. Please note that this Myopia Control Clinic referral form is separate to the general Optometry Referral Form.