OPHTHALMIC REFERRAL

Date of Referral: ....

SEND COMPLETED FORM TO

Fax: 3844 2246 or

Email: reception@qei.org.au

Dear Dr Tai Smith

Patient Information

Name: .... DOB: ....

Address: ....

....

Phone (H): ....

Phone (M): ....

Referred for:

EYELID **ORBIT** **LACRIMAL** **OTHER**

Describe request, concern or problem:

....

....

....

Referring Practitioner: ....

Address: ....

Provider Number: ....