



GARDEN CITY
EYE CLINIC

DR MICHAEL STATHAM
MBBS (Hons 1) BAppSc (Optom) (Hons 1) FRANZCO
Monash Fellowship (Cataract Surgery & Medical Retina)

OPHTHALMOLOGIST

REFERRAL

PATIENT DETAILS

Date of Referral _____ D.O.B. _____

Name _____

REASON FOR REFERRAL

- | | |
|---|------------------------------------|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Pterygium |
| <input type="checkbox"/> Retina | <input type="checkbox"/> Eyelid |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other |

Clinical Notes _____

REFERRER DETAILS

Name _____

Provider Number _____

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