



Reason for Referral

Patient Details Name: Date of birth: Phone: Reason for Referral ☐ Blurred Vision ☐ Vein Occlusion ☐ Retinal Detachment ☐ Diabetic Retinopathy ☐ Floaters/Flashes ☐ Macular Degeneration ☐ Other

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☐ Cataract	
☐ Glaucoma	
☐ Other	
Referring Doctor/Opto	ometrist
Name:	
Provider No:	
Signature:	
Address:	
Phone:	Date:



Dr James Leong A/Prof Adrian Fund

Dr Michael Chilov

Dr Raj Chalasani

Dr Simon Nothling

Dr Emily Gregory-Roberts

Dr Amv Pai

Dr Richard Parker

Dr Thushanthi Ramakrishnan

Surgical & Medical Retina

Surgical & Medical Retina, Ocular Oncology

Medical Retina/Macular Degeneration, Cataract Surgery Medical Retina/Macular Degeneration, Cataract Surgery

Medical Retina/Macular Degeneration/Uveitis, Cataract Surgery

Cataract & Glaucoma Surgery

Medical Retina & Uveitis Specialist, General Ophthalmology Medical Retina & Cataract Surgery

Cataract & Oculoplastic Surgery



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For your appointment

Allow 2 hours for your first consultation.

You will be unable to drive for up to 4 hours following your appointment.

Please bring:	Referral letter from the doctor or optometrist.
	☐ Spectacles/sunglasses and spectacle prescription.
	☐ If wearing contact lenses, please bring a contact lens case.
	☐ A summary of your medical history, medications and allergies.
	Medicare and Private health insurance card.