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REFERRAL TO:

- ☐ **Dr James Charles McAlister** MBBS BSc (Hons) MD FRCOphth FRANZCO
Associate Professor
Consulting in Cornea, Cataract, Refractive Surgery & Ocular Surface Diseases
- ☐ **Kylie McNeill** BAppSc (Optom) (Hons) GradCertOcTher FBCLA
Clinical Optometrist & Specialised Contact Lens Fitting

PATIENT DETAILS:

Name: _____ **DOB:** ____ / ____ / ____

Address: _____ **Phone:** _____

Clinical Findings: _____

Refractive Findings: RE: _____ (6 / __) LE: _____ (6 / __)

Intraocular Pressure: RE: _____ mmHg LE: _____ mmHg (at __)

REFERRER DETAILS:

Referrer's Name: _____ **Practice:** _____

Address: _____ **Provider number:** _____

_____ **Date:** _____

_____ **Signature:** _____

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