**SPECIALIST EYE CENTRE**

***Please fill out this form in BLOCK letters BEFORE your arrival – thank you!***

(Circle) Mr/Mrs/Ms/Miss/Dr Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Given Names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Town/Suburb\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

P/Code \_\_\_\_\_\_\_\_\_\_\_Telephone H) \_\_\_\_\_\_\_\_\_\_\_\_\_W)\_\_\_\_\_\_\_\_\_\_\_\_\_M)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we release information to this person? Yes/No Your signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ref.No:\_\_\_\_\_\_\_\_\_ Expiry date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private Health Insurance Fund Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Membership Number \_\_\_\_\_\_\_\_\_\_\_

Do you have an Optometrist – Yes / No Optometrist name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***NAME OF YOUR USUAL FAMILY DOCTOR/GP*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please circle) Pension/Veterans Affairs 🡪 Card Colour………………

Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_

IF THIRD PARTY COMPENSATION/WORKER’S COMPENSATION:

Solicitor/Employer’s Name and Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim Number (if available) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of……(circle correct response please).

Asthma Yes No Please list medications you are currently taking:

Heart Disease Yes No …………………….. …………………………..

Diabetes Yes No …………………….. …………………………..

High blood pressure Yes No …………………….. …………………………..

Strokes or similar Yes No …………………….. …………………………..

Glaucoma Yes No …………………….. …………………………..

Eye Operation Yes No …………………….. …………………………..

Eye Injury Yes No

Cataracts Yes No Please list any medication you are allergic to:

Medication: Reaction:

Other conditions………………….... ………………………….. …………………….. …………………………………… ………………………….. .…………………….

Do you wear contact lenses? Yes No

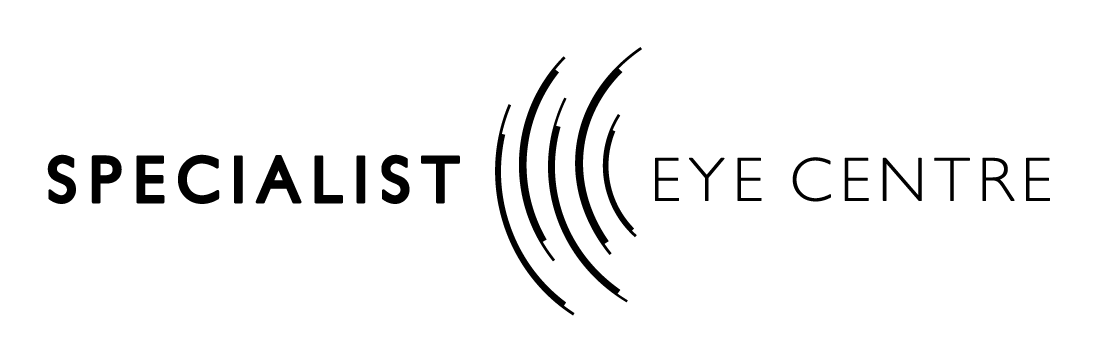
Have you ever smoked? Yes No

Do you wear glasses for TV or long distance? Yes No

Are you on Aspirin, Warfarin, Astrix, Plavix or other blood thinning medications? Yes No

Do you consent to release of information about you to your other doctors/optometrist? Yes No

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



271 Russell Street, BATHURST, NSW, 2795 Lithgow Specialist Medical Centre, Lithgow Hospital

Tel: (02) 6331 3989, Fax: (02) 6332 1106 Col Drewe Drive, LITHGOW, NSW, 2790

………………………………………..

………………………………………..

………………………………………..

Dear ………………………

**Welcome to the Specialist Eye Centre.**

**An appointment has been made for you with Dr………………….........at Bathurst / Lithgow on …………………..………………………………… at …………….. am/pm.**

You may be in the rooms for about 1 to 2 hours from your appointment time. This allows time for most standard investigations. Unfortunately, emergencies do occur, and delays can be experienced.

If you wear contact lenses, please bring your case with you as you will need to remove your lenses. If you wear glasses please bring your most up-to-date pair.

It is recommended that you bring sunglasses with you to prevent glare after you have had your eyes dilated. *It is not advisable to drive immediately following your consultation*. You may need to wait at least one hour for your eyes to adjust before driving or ask someone to drive you home.

If you have a DVA gold card, or a pension entitlement card, please bring your card with you.

Please make arrangements to pay the account on the day. The cost for the initial consultation is $160.00 ($125.00 if you have a full pension entitlement). Part of this is refundable from Medicare. *If any other test/procedures are required on the day there will be an extra charge*. Accepted methods of payment are cash, cheque, MasterCard, Bankcard or Visa card (not Amex or Diners Club).

Please bring any relevant correspondence and the referral letter with you to your appointment.

***Please fill in the accompanying form and bring it with you to the appointment.***

**Late arrivals** – If you are more than 15 minutes late your appointment will be rescheduled to another day. Please note a “non-attendance” fee of $35.00 will be charged for cancelled or postponed appointments with less than 24 hours notice.

If you are in a wheelchair or need partial or full assistance, please bring a suitable carer/family member with you. This person is welcome during the consultation if you wish. If you have any questions, please contact us directly on (02) 6331 3989.

Yours sincerely,

Practice Manager