Auckland Region Ophthalmology Services
Referral for Glaucoma Patients

Adequate completion of the following is the **minimum requirement for referrals**, we will consider all referrals from GPs, optometrists and specialists for patients domiciled in the Auckland, Counties and Waitemata DHB catchment areas.

STEP 1 – Patient Information

First Name(s)	**Surname**
Address	**All Contact Phone Number(s)**
Date of Birth	**NHI Number** (if available)
Gender Male ☐ Female ☐	**Ethnicity**

STEP 2 – Ophthalmic Information (mandatory)

Please choose one category. *(Remember ACC cases can be seen by private ophthalmologists.)*

	Tick
A: Angle closure (i.e. apposed angle 180 degrees or more)	
B: Eye(s) with markedly raised IOP (>/= 28 on more than one occasion – detail below)	
C: Probable/Treated glaucoma	Tick
Date last seen ____ Previous treatment details provided (attached)	
Typical glaucomatous visual field loss corresponding with IOP asymmetry and disc appearance OR	
Progression of field loss in a typical glaucomatous pattern.	
DHB glaucoma patient apparently lost to follow-up	
D: Pigment Dispersion syndrome	
E: Possible glaucoma, (i.e. 2 or more of the following) :	Tick
IOP 22 – 27	
IOP asymmetry of 5 or more	
Repeated visual field abnormality	
OCT abnormality corresponding with visual field defect	
Pseudo exfoliation	
Documented disc haemorrhage	
Strong family history (e.g. sibling or parent on treatment for glaucoma)	

Best Corrected Vision (Glasses or Pinhole)			**RE: VA** ____/____	**LE: VA** ____/____
Please include if possible:				
IOPs	**RE:**	**LE:**	**Method:** (Goldman preferred)	**Time:**
Refraction:	**RE:**		**LE:**	
Central corneal thicknesses:		**RE:**		**LE:**

Please include as many copies of visual fields, and colour copies of OCT scans and disc photos, as available.

Other Information:

STEP 3 – Referrer Information (for return correspondence)

Referrer Details (Name, Address, Phone Number)	**GP Details** (if not the referrer)	
Referrer Signature [not required for e-Referral]	**Date of Assessment**	

Central Referrals Office, Greenlane Clinical Centre, Private Bag 92 189, Auckland Mail Centre, Auckland 1142, Fax (09) 638 0402
or, Manukau SuperClinic™, PO Box 98743, Manukau 2241, Fax (09) 277 1600