ADRIAN FUNG
RETINAL SURGEON

Ophthalmology Referral

Dear,
Associate Professor Adrian Fung, thank you for seeing:

Patient Details

Name: ____________________

Date of birth: ____________________

Phone: ____________________

Clinical information

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Reason for Referral

- [ ] Blurred Vision
- [ ] Cataract
- [ ] Distortion
- [ ] Epiretinal Membrane
- [ ] Flashes/Floaters
- [ ] Macular Hole
- [ ] AMD
- [ ] PVD
- [ ] Diabetic Retinopathy
- [ ] Retinal Tear/Detachment
- [ ] Retinal Vascular Occlusion
- [ ] Vitreous Haemorrhage
- [ ] Central Serous Chorioretinopathy

Other ____________________

Referring Doctor / Optometrist

Name: ____________________

Provider No: ____________________

Address: ____________________

Phone: ____________________

Signature: ____________________ Date: ____________________

Please call Associate Professor Fung's nearest clinic for an appointment, fax this referral and bring it on the day of your appointment