

# MBL EYE SURGEONS



## Referral for (please circle):

**Dr Augustino Clark**

Vitreoretinal Surgeon  
and Medical Retina

**Dr Roy van Eijden**

Glaucoma, Oculoplastics, Paediatrics  
and Neuro-Ophthalmology

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

### Refraction:

**R** \_\_\_\_\_ / \_\_\_\_\_ x \_\_\_\_\_ 6/ \_\_\_\_\_

**L** \_\_\_\_\_ / \_\_\_\_\_ x \_\_\_\_\_ 6/ \_\_\_\_\_

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Cataract        | <input type="checkbox"/> Pterygium   | <input type="checkbox"/> Oculoplastics            |
| <input type="checkbox"/> Surgical Retina | <input type="checkbox"/> Glaucoma    | <input type="checkbox"/> Ocular Motility          |
| <input type="checkbox"/> Medical Retina  | <input type="checkbox"/> Paediatrics | <input type="checkbox"/> Vision/Amblyopia Therapy |
| <input type="checkbox"/> Other _____     |                                      |   |

**BACKGROUND:** \_\_\_\_\_

\_\_\_\_\_

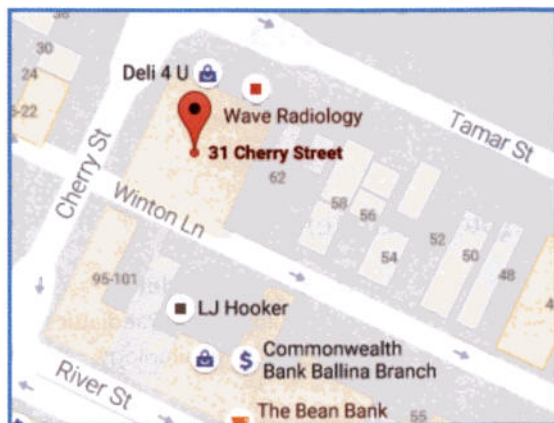
\_\_\_\_\_

\_\_\_\_\_

Referrer: \_\_\_\_\_ Provider No: \_\_\_\_\_

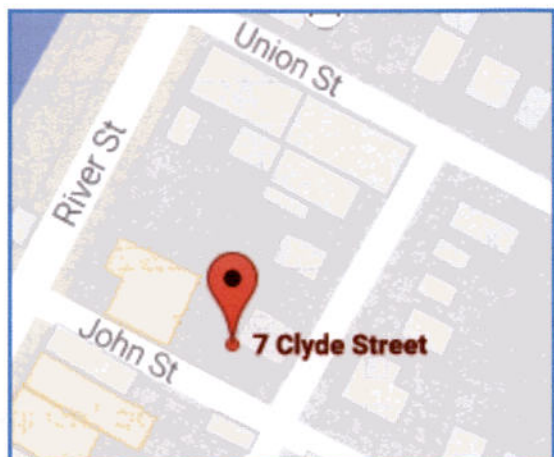
Address/Practice: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



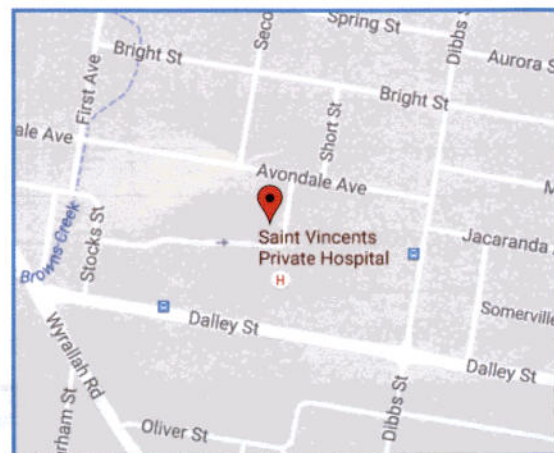
## **BALLINA**

Suite 7, Level 1,  
31 Cherry Street



## **MACLEAN**

7 Clyde Street



## **EAST LISMORE**

61 Avondale Avenue  
(Within St. Vincent's  
Hospital Grounds)