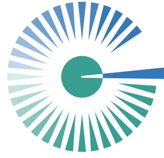

Australian & New Zealand Registry of Advanced Glaucoma

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REFERRAL FORM

Does patient have Advanced Glaucoma?	Yes ☐	No ☐

Referral Comments: ....

PATIENT DETAILS *(REQUIRED)*

Surname:	First Name:		
Date of Birth:	Gender:	Male ☐	Female ☐

Address: *(for postage of DNA collection kit)* ....
State: .... Postcode: ....

Phone Number/s:	Email:

REFERRAL SOURCE *(REQUIRED)*

Eye Practitioner:		GP:	
Address:		Address:	
State:	Postcode:	State:	Postcode:
Phone:	Fax:	Phone:	Fax:
Email:		Email:	

PATIENT CLINICAL DETAILS *(IF KNOWN)*

***Please tick if patient is aware they will be contacted** ☐

Circle ALL Diagnoses	POAG	PXF	PDS	Steroid Responder	Angle Closure	Primary Congenital Glaucoma

Anterior Segment Dysgenesis: Yes ☐ No ☐	Systemic features consistent with Riegers / Axenfeld Syndrome: Yes ☐ No ☐	Age at diagnosis: (years)

Family History of Glaucoma? Yes ☐ No ☐	If Yes, please list number & relationship:			
BCVA:	RE		LE	
Highest Recorded IOP (mmHg):	RE	Was this the pressure at diagnosis? Y / N	LE	Was this the pressure at diagnosis? Y / N
Refraction (spherical equivalent):	RE		LE	
Central corneal thickness (μm):	RE		LE	
Cup disc ratio:	RE		LE	
Glaucoma Surgery:	RE	Yes ☐ No ☐	LE	Yes ☐ No ☐
Laser Trabeculoplasty: *(Please Circle)*	RE	PI ALT SLT	LE	PI ALT SLT

Mean Deviation (dB): *(recent reliable field)*	RE	LE	Central field loss (<10°):	RE: Yes ☐ No ☐	LE: Yes ☐ No ☐

OFFICE USE ONLY

Request Received	**DNA Kit Posted**	**DNA Kit Received**	**Feedback**
Date:	Date:	Date:	Date:
By:	By:	By:	By:
Issue:	Issue:	Issue:	Issue:
	ID:		

Funded by The Eye Foundation www.eyefoundation.org.au

SUBMIT FORM