MACULAR DEGENERATION NEW ZEALAND

Patient Referral Form

This referral form is available for use by health professionals to refer their patients to Macular Degeneration NZ so that they can receive information, support and guidance.

Referrer's details

Please tell us your name so that we can acknowledge you when we contact the patient.

Referrer's name _____

Referring organisation _____

Contact email _____

Contact phone _____

Referrer type *(Select one)*:

- ◯ Optometrist
- ◯ Ophthalmologist
- ◯ Orthoptist
- ◯ General Practitioner
- ◯ Pharmacist
- ◯ Practice Manager
- ◯ Nurse
- ◯ Aged Care worker

Other (*please specify*): _____

Patient/Client details

Please ask your patient to agree to this statement and tick the box below:

I agree for this practice to provide my personal information (name, contact details, information about my eye health) to Macular Degeneration NZ so that MDNZ can contact me with information and advice of their services.

Patient agrees (*please tick*): ◯ Date _____

Patient name _____

Patient phone _____

Patient email _____

Reason for referral and any other comments

We take great care with your personal information.
Please see our Privacy Policy which is published on our website **www.mdnz.org.nz**
See **www.mdnz.org.nz** Helpline **0800 622 852** Email **info@mdnz.org.nz**

Submit form