

ABEL • ROBSON • FALKENSTEIN
OPTOMETRISTS

You have booked for a comprehensive eye examination and we would like to thank you for letting us look after your eye health and vision care needs. In order to give you the best care possible and provide the most beneficial use of your time with us, please read the following and bring with you the requested items and forms. Please arrive 10 minutes prior to your scheduled appointment time in order to complete the check-in process. Our optometrists want to give you the most thorough care possible, so please allow around 40 minutes for your eye examination.

Behavioural Eye Examinations

A behavioural eye examination may require us to perform additional tests, i.e. visual perceptual testing, which is not covered under Medicare or your private Health Fund. We encourage parents to accompany their child to the appointment and to refrain where possible from bringing siblings to the eye examination.

Pupil Dilation

To better evaluate your eye health, the optometrist may need to use drops to dilate your pupils. Side effects of pupil dilation include temporary light sensitivity and reduction in reading vision and sometimes distance vision. It is therefore advisable to bring your sunglasses and/or arrange a driver to take you home. The optometrist may need to run additional tests such as the Optical Coherence Tomography (OCT) or Topography, which will incur an additional cost.

Fees

Our standard fee for a first consultation ranges from \$120 to \$190. In most cases there will be a rebate from Medicare. Additional testing that maybe required will incur an extra cost

Please bring the following to your appointment:

- The completed questionnaire form
- Your Medicare card, Private Health Insurance card or Veteran Affairs card as appropriate.
- All prescription spectacles you currently use, and your sunglasses.
- If you wear contact lenses, please wear them to your appointment and bring your contact lens case. It is helpful to bring the boxes or lens packets that indicate the lens manufacturer, brand name, power, base curve and diameter.
- Any prescription and non prescription eye drops and ointments that you use daily or occasionally.
- Any referrals or relevant reports from a Psychologist, Optometrist, Speech Pathologist or OT.

We are situated at **18a Starkey St, Forestville**. Parking is available behind the practice (enter through Violet Avenue as per map).



We look forward to seeing you soon! Do not hesitate to contact us if you have any questions.

ARF BEHAVIOURAL FAMILY VISION CARE

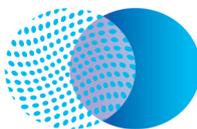
18A Starkey St
Forestville NSW 2087

P 02 9452 1033 E info@forestvilleoptom.com.au
F 02 9975 4608 W www.forestvilleoptom.com.au

Mark Falkenstein
PROV 611643A

Carolyn McIlvin
PROV 2051734T

Paola Duarte
PROV 5369881X



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PRESCHOOL CHILD – PARENT’S QUESTIONNAIRE

In order to allow more time to devote to the assessment of your child, it would be appreciated if you could provide us with the following information.

Date _____

Child's Name _____

Date of Birth: _____ Age _____

Parent's Names: _____

Email _____

Address: _____

Phone(H) _____ (M) _____

Family GP _____

A. Entering Complaint / Major Concern:

1. Briefly detail your main concern:

2. Who first recommended our practice to you.

B. Observations: Do you notice any of the following? Please ✓

Unusual redness of the eyes Unusual redness of the lids Crusted Lids

Styes or sores on lids Excessive tearing Unusual lid droopiness Eye turn Excessive rubbing of eyes Frequent closing of one or both eyes

Unusual clumsiness and bumping into objects

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C. Visual History:

1. Has there been previous visual examination? When? _____ Which practitioner _____
2. Reason for previous examination _____
3. Previous treatment: Spectacles Patching Surgery Medication Vision Therapy
4. Family visual Difficulties. Are there any family members with visual difficulties. Yes No
If Yes. What? Eye turn Long/short sighted Colour Vision deficit
Diabetes Glaucoma Learning Difficulties

D. Developmental History

1. Was pregnancy and birth free from complications: Full term Premature Complications
2. Is your child Right or left handed Right Left
3. Has your child progressed developmentally in the following areas as you would expect?

Milestones	
General growth	
Crawled	
Walked without assistance	
Spoke first words	
General coordination	

E. General Health :

1. Please describe your child's present health/ medical conditions: _____
2. Are any medications currently being taken Yes No If yes what? _____
3. Has the child ever experienced severe illness, fever, injury or physical impairment? Yes No
if yes, please explain _____
4. Please ✓ any condition that applies: Allergies Extreme fatigue Irritability Poor appetite
Poor sleeping habits Temper tantrums Destructive behaviour Epilepsy Impulsivity

NOTE:

1. Please include any additional information, such as reports from other professionals (Speech Therapist, Occupational Therapist, School Counsellor), that will help us better understand your child.
2. Please bring any spectacles that have been prescribed for your child to the consultation. If you have the prescription please bring this in.

Thank you