



ABEL • ROBSON • FALKENSTEIN
OPTOMETRISTS

Welcome to our Practice

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 at least 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. Reports requested by patients are ordinarily not included in the consultation. Comprehensive reports will incur an additional time based fee.

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.
- 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 all the lens details.
- 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.

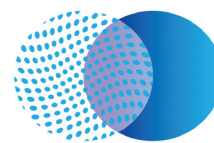
We are situated at **18a Starkey St, Forestville**. Parking is available behind the practice (enter through Violet Avenue as per map).

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



ARF BEHAVIOURAL FAMILY VISION CARE

Welcome to Our Practice




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Personal Details

Child's Full Name Male [] Female []
Parent/Guardian's Name Male [] Female []
Address Postcode
Parent/Guardian's Email Child's Date of Birth / /
Parent/Guardian's Mobile
Does the child live with both parents at the same address? Yes [] No []
Child's Medicare Number Ref Number Expiry Date / /
Is your child covered by Private Health Insurance? Yes [] No []
Private Health Fund Provider
GP's Name GP's Phone
GP's Address Postcode
What is the main reason for your visit today?

Medical History


 Has your child previously be assessed by any of the following? If so, please bring reports
Educational Psychologist [] Optometrist [] Speech Pathologist []
Occupational Therapist [] Ophthamologist [] Paediatrician []
Has your child been diagnosed with any behavioural or learning difficulties? Yes []... No []
If yes, please specify:

Does your child currently wear glasses? Yes []... No []
Does your child have other health conditions we should be aware of?


Please list any medications your child is currently taking:

Has your child ever been admitted to hospital? Was general anaesthesia required?

Education

 Name of School
Year Level
Is your child having difficulty with any of the following?
Reading [] Spelling [] Writing [] Maths [] Behaviour []
Has your child repeated a grade? Yes []... No []

Birth and Development

 Did you experience any complications during birth? Yes []... No []
If yes, please specify:

At what age did your child start to crawl?

At what age did your child start to talk?

Is your child right handed or left handed? Left [] . Right []

Eye Teaming Ability

Does your child:

- Complain of double vision.....Yes []..No []
- Complain of headachesYes []..No []
- Complain of moving words on the page...Yes []..No []
- Cover or close one eye when reading.....Yes []..No []
- Have an eye that turns inward or outward constantly when tiredYes []..No []
- Have head at an angle when readingYes []..No []
- Have poor reading comprehension.....Yes []..No []
-

Focusing Ability

Does your child:

- Avoid small print.....Yes []..No []
- Become fatigued when readingYes []..No []
- Complain of blurred vision when reading ...Yes []..No []
- Complain of eye strain.....Yes []..No []
- Complain of headachesYes []..No []
- Have a short attention span when reading Yes []..No []
- Hold a book very closeYes []..No []
- Rub his or her eyes when concentrating Yes []..No []
-

Tracking Ability

Does your child:



- Lose place on page often.....Yes []..No []
- Skip words and lines often.....Yes []..No []
- Use fingers to keep place.....Yes []..No []
-

Visual Processing Ability


Does your child:

- Respond orally but not in writingYes []..No []
- Have difficulty following a series of instructionsYes []..No []
- Not recognise the same word repeated on a pageYes []..No []
- Have trouble learning left and right.....Yes []..No []
- Have untidy handwritingYes []..No []
- Mistake words with similar beginnings ...Yes []..No []
- Have poor organisation on a page.....Yes []..No []
- Have poor reading comprehension.....Yes []..No []
- Have poor recall of visual materialYes []..No []
- Reverse letters and numbers.....Yes []..No []
- Seem to know material but does poorly on written materialYes []..No []
- Copy from the board to their book slowly..Yes []..No []
- Have trouble learning letter/sound correspondence.....Yes []..No []
- Have trouble learning basic mathYes []..No []
- Have trouble with spelling and sight word vocabulary.....Yes []..No []
- Able to tie shoelaces.....Yes []..No []
- Ride a two wheeler with no trainer wheelsYes []..No []
- Clumsy, falls and bumps into things oftenYes []..No []
-

How did you hear about us?

- | | | |
|--|--|--------------------------------------|
|  | Relative / Friend / Previous Patient.....Yes [] | Facebook / Social MediaYes [] |
|  | Your GP.....Yes [] | Print AdvertYes [] |
| | Internet Search / Our Website.....Yes [] | Other |
-

Future communication

-  Are you happy to receive occasional communications including appointment reminders, eye health information and special offers by mail, email and sms?.....Yes [].....No []

Signature Date / /

Thank you for entrusting us with your eyecare

Privacy Statement: Our practice respects your privacy and will comply with the Privacy Act and the Australian Privacy Principles when handling your personal information (including health information). We use your personal information to help us provide services to you. We may also use your personal contact information to send you information regarding eye health, eye care and eyewear, with your consent. By providing the information requested in the first three sections of this form we will be able to make an informed decision on how to best meet your eye care and eyewear needs. We may also need to provide some personal information to third party suppliers (such as providers of mail-out and electronic distribution services and eyewear suppliers) if and to the extent necessary for them to provide the relevant goods or services (for example prescription eyewear or contact lenses). You can access all the personal information that we hold about you.
