



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

## High Myopia Assessment Referral Form

**From:** \_\_\_\_\_

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

**Tel:** \_\_\_\_\_

**To: Optometry Clinic,  
School of Optometry, Room A034, The  
Hong Kong Polytechnic University**

e-submission: <https://polyu.hk/wmHZd>



**Tel: 2766 5225**

**Fax: 2362 5440**

**Patient name:** \_\_\_\_\_

**Gender: M / F**

**Age:** \_\_\_\_\_

**Your Ref:** \_\_\_\_\_

**Tel:** \_\_\_\_\_

**I would like to refer the above patient for the following assessment(s):**

Clinical Procedures

Assessment Fee

- |  |            |
|--|------------|
| <input type="checkbox"/> Full High Myopia Assessment<br>(including SD-OCT imaging, automated perimetry and axial length measurement) | HK \$2,500 |
| <input type="checkbox"/> SD-OCT imaging + Axial length measurement   | HK \$1,800 |
| <input type="checkbox"/> Automated perimetry + Axial length measurement  | HK \$1,100 |
| <input type="checkbox"/> + Dilated fundus examination  | + HK \$480 |

**Manifest subjective refraction / spectacle prescription\*:**

	Sphere	Cylinder	Axis	VA	Add
OD					
OS					

\* Delete as appropriate

**Specific remarks:** \_\_\_\_\_

Notes:

1. An updated subjective refraction result must be provided by the referring practitioner before the assessment
2. Unless otherwise stated, HFA will be performed with Central 24-2 threshold SITA FAST, white-on-white testing condition.
3. SD-OCT imaging includes scanning on macular and peripapillary regions. Scanning patterns, unless specified by the referring practitioner, are subject to our specialist's decision.
4. A written report, enclosed with the relevant printouts, will be sent to the referring practitioner within 14 working days after the consultation.

\_\_\_\_\_  
(Optometrist/ Ophthalmologist)