



# Optometrists Board of Queensland

Ocular Therapeutics Survey for Month of \_\_\_\_\_ Year \_\_\_\_\_

Please return to:

Principal Coordinator  
Optometrists Board of Queensland  
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*Please complete the shaded fields as a minimum requirement, especially your name and the month this survey covers.*

<b>Endorsed registrant's name*</b>				
	<i>* data will be de-identified for external reporting purposes</i>			
<b>Type of practice</b>	<b>Optometry practice</b>		<b>Ophthalmology practice</b>	
<b>Practice location (please tick)</b>	<b>Inner Metro</b>	<b>Outer Metro</b>	<b>Regional Centre</b>	<b>Rural</b>

Did you prescribe any therapeutic agents during the reporting month? Yes / No

Type	Pharmaceutical name	Number	Type	Pharmaceutical name	Number
<i>Topical ocular anti-infective agents (anti-bacterial, anti-viral)</i>			<i>Topical ocular anti-allergy agents (anti-histamine, mast cell stabilisers)</i>		
	Acyclovir			Ketotifen	
	Bacitracin			Olopatadine	
	Chloramphenicol		<i>Topical non-steroidal anti-inflammatory agents (NSAIDs)</i>		
	Ciprofloxacin			Diclofenac	
	Framycetin			Flurbiprofen	
	Gentamicin			Ketorolac	
	Gramicidin		<i>Topical ocular steroid preparations</i>		
	Neomycin			Fluorometholone	
	Ofloxacin			Hydrocortisone	
	Polymixin		<i>Mydriatics, miotics and cycloplegics</i>		
	Tetracycline			Atropine	
	Tobramycin			Homatropine	
				Pilocarpine	

Did you refer any patients requiring a prescription to a medical practitioner for the sole purpose of allowing the patient to claim the PBS benefit? **YES / NO**

If yes, how many patients did you have to refer?

How many patients have you treated with Therapeutic Agents?

Were there any side-effects of the treatment, and if so, list these: **YES / NO**

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Are there any issues/difficulties you are experiencing in incorporating therapeutics in your practice you wish to comment on?

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