EYE CLINIC Level 4, High St The Prince of Wales hospital Randwick NSW 2031	Ph 9382 2261 Fax 9382 2281	Patient Referral Form Assessment for Cataract Surgery

Outpatient Clinic use only	
Referral received:	/ /
Referrer notified of receipt:	/ /

Referral to:

Patient / client details

Patient name:		Address:	
Title:	Mr ☐ Mrs ☐ Ms ☐ Miss ☐		
Medicare number:		Date of birth:	/ /
Sex/gender:	**M** (male) ☐ **F** (female) ☐ **X** (indeterminate/intersex/unspecified) ☐		
Phone:	W (work) H (home) M (mobile)		
Email:		Communication preference: Phone W ☐ Phone H ☐ Phone M ☐ Email ☐	
Carer name (if appropriate):		Phone:	
		Email:	
Identifies as of Aboriginal or Torres Strait Islander origin:	Yes ☐ No ☐	Interpreter required: Language:	Yes ☐ No ☐
Special needs/reasonable adjustments required for disability:	Yes ☐ No ☐	Description of required adjustments:	
GP name (if not referrer):		Optometrist name (if not referrer):	
Phone:		Phone:	
Email:		Email:	
Please confirm that the patient understands they are being referred for assessment of their cataract for surgery ☐			

Clinical details

Best correct visual acuity (BCVA)	Right eye..... Left eye..... To be completed by GP or an optometrist	Date / /
Level of difficulty experienced by patient due to sight issues:	No difficulty ☐ Some difficulty ☐ Moderate difficulty ☐ Extreme difficulty ☐ E.g. Recognising faces, reading newspaper text or TV subtitles, seeing to walk on uneven surfaces	
Patient's driving status:	Has driving licence ☐ Drives professionally ☐ Does not have driving licence ☐	
Falls experienced by patient in past year:	Two or more ☐ Less than two ☐ None ☐ A fall can be described as an unexpected event in which the patient has come to rest on the ground, floor, or lower level	
Any previous surgery for cataracts:	Yes ☐	Description: Right eye ☐ Left eye ☐ — No ☐
Any other co-existing conditions:	Yes ☐	Amblyopia ☐ Diabetes ☐ Glaucoma ☐ Only functioning eye ☐ Other ☐..... — No ☐
Any current medication:	Yes ☐	Description and dosage: — No ☐

Referrer details

Name:		Optometrist ☐ Ophthalmologist ☐ GP ☐	
Provider number:		Phone:	
Email:		Fax:	
Signature:		Date:	/ /

Other details if required

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