

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 <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/>		
Medicare number:		Date of birth:	/ /
Sex/gender:	M (male) <input type="checkbox"/> F (female) <input type="checkbox"/> X (indeterminate/intersex/unspecified) <input type="checkbox"/>		
Phone:	W (work) <input type="checkbox"/> H (home) <input type="checkbox"/> M (mobile) <input type="checkbox"/>		
Email:		Communication preference: Phone W <input type="checkbox"/> Phone H <input type="checkbox"/> Phone M <input type="checkbox"/> Email <input type="checkbox"/>	
Carer name (if appropriate):		Phone:	
		Email:	
Identifies as of Aboriginal or Torres Strait Islander origin:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Interpreter required:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Special needs/reasonable adjustments required for disability:	Yes <input type="checkbox"/> No <input type="checkbox"/>	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 <input type="checkbox"/>			

Clinical details

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

Referrer details

Name:	Optometrist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> GP <input type="checkbox"/>		
Provider number:	Phone:		
Email:	Fax:		
Signature:	Date:		/ /

Other details if required