SYDNEY EYE HOSPITAL OUTPATIENT DEPARTMENT 8 Macquarie Street, Sydney, NSW, 2000 Phone: 9382 7046 SESLHD-SSEH-EyeReferrals@health.nsw.gov.au	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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