

<NAME OF OUTPATIENT CLINIC>

Patient Referral Form

<Address of clinic>

Assessment for
Cataract Surgery

<Phone, fax and email of clinic>

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)	H (home)	M (mobile)		
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