EYE CLINIC, Prince of Wales Hospital
Level 4, High Street
Randwick NSW
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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:			
Medicare number:		Date of birth:	
Sex/gender:	Not Stated		
Phone:	W (work)H (home)M (mobile)		
Email:	None recorded.	Communication preference: Phone W ☐ Phone H ☐ Phone M ☐ Email ☐	
Carer name (if appropriate):		Phone:	
		Email:	
Identifies as of Aboriginal or Torres Strait Islander origin:		Interpreter required: Language:None Recorded.	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	
When wearing glasses the patient can:	Recognise faces ☐ Read newspaper text or TV subtitles ☐ See 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