SYDNEY EYE HOSPITAL
Eye Outpatient Department
Phone: 9382 7046 Fax: 9382 7354
Email: seslhd-sseh-eyereferrals@health.nsw.gov.au

Please refer to our website and 'INFORMATION FOR REFERRERS' prior to completing this form.

Referral Template – Cataract

Please do not use this template for medical retina or glaucoma referrals

Each sub-specialty clinic has a strict set of inclusion criteria. Read our referral guidelines by scanning the QR code. **If this referral is deemed inappropriate or incomplete, you will be contacted ASAP. Waiting times for non-urgent appointments may be lengthy. Please refer patients to their closest public hospital eye clinic, if possible - see list on reverse side.**

PATIENT INFORMATION:

Surname: _____ Given Names: _____

Date of Birth_____/____ /_____ Gender: M / F

Address: _____Postcode:_____

Phone: (H) _____ (M) _____

Medicare No: _____

Language Spoken at home: _____ Interpreter Required? Yes / No

Are you of Aboriginal and/or Torres Strait Islander origin?

☐ NO ☐ Aboriginal origin ☐ Torres Strait Islander origin ☐ Both ☐ Declined to respond ☐ Unknown

REASON FOR REFERRAL:

Consideration for first Cataract Surgery ☐

Second Eye surgery ☐

VISION RELATED NEEDS:

Does the cataract affect the patient's sight, social circumstance or quality of Life? YES / NO

If YES:

- Complete CatQuest 9SF with the patient and attach it to this referral – *can be downloaded on SSEH website*

Does the patient wish to have surgery if it is offered? YES / NO

(*If NO, refer to SSEH referral guidelines*)

VISUAL ACUITY - test both eyes individually *(to be completed by Optometrist or Ophthalmologist)*

Best Corrected Visual Acuity: Right Eye Left Eye

Glare or contrast sensitivity (based on clinical assessment) _____

Intraocular pressure: Right Eye _____ mmHg Left Eye _____ mmHg

Subjective Refraction:

_____

_____

_____

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RELEVANT EYE and MEDICAL HISTORY: *(Include any previous eye surgery, where and when it was done and by whom) – See Guideline*

- Glasses / Contact Lens
- Ocular Conditions and management history
- List all medications, *including eye drops*

_____
_____
_____
_____
_____

REFERRER INFORMATION:

Date: ____/____/_____ Referred by: _____

Designation: Optometrist / Ophthalmologist

Address: _____Postcode:_____

Phone: _____ Fax: _____

Email address: _____

Sub-specialty clinic list:

General
Cataract (IOL)
Cornea
Oculoplastic
Ocular Oncology
Surgical Retina (VR)
Neuro-Ophthalmology
Inherited Eye Disease
Paediatric/Squint
Glaucoma – use glaucoma referral template
Medical retina/Uveitis – use MR referral template

NSW Public Hospital Eye Clinic list:

Bankstown Hospital	Fax: 9722 8398
Liverpool Hospital	Fax: 8738 4585
Royal Prince Alfred Hospital	Fax: 9515 7520
Royal North Shore Hospital	Fax: 9463 1065
Prince of Wales Hospital	Fax: 9382 2281
Concord Hospital	Fax: 9767 6743
Westmead Hospital	Fax: 8890 6117
Sydney Children's Hospital	Fax: 9382 1461
Westmead Children's Hospital	Fax: 9845 3457

Please return this referral template and relevant imaging to:
seslhd-sseh-eyereferrals@health.nsw.gov.au

Not all referrals are accepted, and you and your patient will be notified ASAP if this is the case.