



## SYDNEY EYE HOSPITAL

Eye Outpatient Department

Phone: 9382 7046 Fax: 9382 7354

Email: [seslhd-sseh-eyereferrals@health.nsw.gov.au](mailto: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*

**There are new NSW state-wide referral criteria for selected conditions within the specialty of Ophthalmology. Visit the NSW Health website to learn more about this.  
Read our referral guidelines by scanning the QR code above.**

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_ Postcode\*: \_\_\_\_\_

*\*If postcode not in SESLHD catchment area please refer patient to their local public hospital eye clinic in the first instance. See list on back of this page.*

Phone: (H) \_\_\_\_\_ (M) \_\_\_\_\_

Email: \_\_\_\_\_

Medicare No: \_\_\_\_\_

Language Spoken at home: \_\_\_\_\_ Interpreter Required? Yes / No

Is patient 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, please do not refer)

#### 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 use
- Ocular Conditions and management history
- List all medications, including eye drops

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#### REFERRER INFORMATION:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Referred by: \_\_\_\_\_

Designation: Optometrist / Ophthalmologist

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email address: \_\_\_\_\_

#### NSW Public Hospital Eye Clinics:

Bankstown Hospital Eye Clinic	Phone 9722 8380 Fax 9722 8398	SWSLHD-Bankstown- OutpatientServices@health.nsw.gov.au
Concord Hospital Eye Clinic	Phone 9767 5333 Fax 9767 6743	slhd-concordeyeclinic@health.nsw.gov.au
RPA Hospital Eye Clinic	Phone 9515 7532 Fax 9515 752	slhd-rpaeyeclinic@health.nsw.gov.au
Royal North Shore Hospital Eye Clinic	Phone 9463 1400 Fax 9463 1065	NSLHD-RNSH- Ophthalmology@health.nsw.gov.au
Sutherland Hospital Eye Clinic	Phone 9540 7286 Fax 9540 7304	seslhd-sutherland- outpatients@health.nsw.gov.au
Liverpool Hospital Eye Clinic	Phone 8738 4599 Fax 8738 4585	sWSLHD- liverpooleyeclinic@health.nsw.gov.au
Westmead Hospital Eye Clinic	Phone 8890 6668 Fax 8890 6117	e-Referrals only – see website
Prince of Wales Hospital Eye Clinic	Phone 9382 2261 Fax 9382 2281	
Sydney Children's Hospital Eye Clinic	Phone 9382 2261 Fax 9382 1461	schn- schoutpatientseyec clinic@health.nsw.gov.au
Westmead Children's Hospital Eye Clinic	Phone 9845 2261 Fax 9845 3949	schn-chw-eyec clinic@health.nsw.gov.au

Please return this referral template and relevant imaging to:

**[seslhd-sseh-eyereferrals@health.nsw.gov.au](mailto: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.*