

# Cataract Referral to ALFRED HOSPITAL Fax to 9076 2709

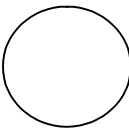
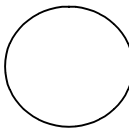
Patient Surname..... Given Name(s) .....

Address .....

..... Postcode..... D.O.B...../...../.....

Patient's Phone\* H..... W..... M..... Referral Date ...../...../.....

(\* The Hospital will call the patient to make the appointment, so please include all phone numbers)

Referral Item	Findings & Details Mark <input checked="" type="checkbox"/> or PRINT	Abnormal Findings & Additional Details Mark <input checked="" type="checkbox"/> or Please Print in BLOCK CAPITALS
Reason for Referral	Cataract R <input type="checkbox"/> L <input type="checkbox"/> OU <input type="checkbox"/>	Other:
Patient Complaint	Vision Complaint R <input type="checkbox"/> L <input type="checkbox"/> OU <input type="checkbox"/>	Other:
Vision	Unaided Specs Pin Hole R 6/... R 6/... R 6/... L 6/... L 6/... L 6/... →	Current Refraction & Best Corrected Acuties Rx R 6/..... L 6/..... Add +
General Health	No Meds <input type="checkbox"/>	Medical Conditions & Meds: <input type="checkbox"/> NIDDM <input type="checkbox"/> IDDM Other:
F.O.H.	Negative for Ocular Disease <input type="checkbox"/>	Ocular Condition: Relationship:
P.O.H.	Spectacles or CL only <input type="checkbox"/>	Other:
Keratometry	Mires sharp or minimal distortion <input type="checkbox"/> →	R _____ x L _____ x <input type="checkbox"/> Irreg astig <input type="checkbox"/> Keratoconus x x Other:
Anterior Segment	Lens Opacities <input type="checkbox"/> Cortical R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Nuclear R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> PSCC R <input type="checkbox"/> L <input type="checkbox"/>	Cornea: Conjunctiva: R <input type="checkbox"/> Iris/Pupil: <input type="checkbox"/> PEX: L <input type="checkbox"/> Other: OU <input type="checkbox"/>
Fundus	NAD R&L <input type="checkbox"/>	Obscured: Glaucoma: R <input type="checkbox"/> Maculopathy: Retinopathy: L <input type="checkbox"/> Other: OU <input type="checkbox"/>
IOP	R .... Time : L .... Date : / /	<input type="checkbox"/> Glaucoma Risk - Previous 3 IOP results R ....., ....., .... L ....., ....., .....
Ocular Meds	No Topical Meds <input type="checkbox"/>	Drug, Concentration & Dosage:
Last Eyecare Consultation	Ophthalmologist <input type="checkbox"/> Optometrist <input type="checkbox"/> as below <input type="checkbox"/>	Cons Date : Practitioner Name:
Other relevant details/findings/reasons for referral:		Sketch Findings
The post-operative refractive target is: R <input type="checkbox"/> Emmetropia <input type="checkbox"/> Other .....		
L <input type="checkbox"/> Emmetropia <input type="checkbox"/> Other .....		R  L

*I am happy to provide cataract aftercare for this patient from 21 days post-op*

## Referring Optometrist Details

Name..... Provider No.....

Signature ..... Date ...../...../.....

Practice Name.....

Address.....

P'Code..... Ph ..... Fax .....

(practice stamp – include Fax No.)