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MonashHealth

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Monash Health Cataract Service -- **Referral Form**

FAX NUMBER: 9594 2273

Surname: (Dr, Mr, Mrs, Miss, Ms)

Other Names

Address

Telephone Land line

Suburb/Town

Postcode

Mobile

Medicare Number

Ref

Expiry

Private Insurance Yes/No

Date of Birth

English speaking: Yes/No Language

Interpreter required: Yes/No

Indigenous Status

Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐

Details of **General Medical Practitioner**

General Health Issues

Ocular History

Visual Difficulties

Visual requirements or demands (driving, work, interests and activities)

Vision and refraction

	Unaided Acuity	**Corrected Acuity**	Pinhole	Sphere	Cylinder	Axis	Prism	Base	Add
RE									
LE									

Description of cataract and any known ocular co-morbidities

IOP

RE……………mmHg

LE……………mmHg

Additional comments

Referrer name:

…………………………………………………………………………

Referrer provider number:

……………………………………………………

Telephone

Address of referrer:

…………………………………………………………………

…………………………………………………………………

…………………………………………………………………

Date / /