



RAH MRN: _____

NAME: _____

DOB: _____ / _____ / _____

Letter of Referral

Dear Treating Optometrist,

We request your assistance in reviewing the above-named patient for their 4 week post operative cataract surgery review.

TO BE FILLED OUT BY OPTOMETRIST

Parameter	Yes	No	Comments
Is the cornea clear	<input type="checkbox"/>	<input type="checkbox"/>	
Anterior chamber reaction	<input type="checkbox"/>	<input type="checkbox"/>	
PCIOL in situ	<input type="checkbox"/>	<input type="checkbox"/>	
CME on OCT retina if OCT available	<input type="checkbox"/>	<input type="checkbox"/>	
Remnant lens material in anterior chamber / inferior angle	<input type="checkbox"/>	<input type="checkbox"/>	
Other eye: is cataract surgery needed	<input type="checkbox"/>	<input type="checkbox"/>	

The patient subjective refraction with BCVA in the operated eye		
If available, post operative keratometry / refraction		
Intraocular pressures	Left eye:	Right eye:
Do you feel follow up at the RAH is necessary and for what reason?		

If no RAH follow up is necessary, please review patient yearly or as appropriate.

Thank you for reviewing the patient and responding to HealthRAHOPDReferrals@sa.gov.au

Best Regards,

Ophthalmology
Outpatient Department
Royal Adelaide Hospital