

## PRIORITY CATARACT & REFRACTIVE REFERRAL

|                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                              |                |
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| <b>PATIENT DETAILS</b>                                                                                                                                                                                                                                                                                                               |                                                                                                                                                              |                |
| NAME:                                                                                                                                                                                                                                                                                                                                | DOB:                                                                                                                                                         | CONTACT PHONE: |
| LANGUAGE PREFERENCE (IF APPLICABLE): <input type="checkbox"/> ENGLISH <input type="checkbox"/> MANDARIN <input type="checkbox"/> CANTONESE <input type="checkbox"/> KOREAN <input type="checkbox"/> OTHER                                                                                                                            |                                                                                                                                                              |                |
| <b>CLINICAL DATA</b>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                              |                |
| <b>VISUAL ACUITY AND REFRACTION:</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                              |                |
| RE: _____ With Glasses: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                     |                                                                                                                                                              |                |
| LE: _____ With Glasses: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                     |                                                                                                                                                              |                |
| <b>LIFESTYLE &amp; GLARE IMPACT:</b>                                                                                                                                                                                                                                                                                                 | <b>DIAGNOSTIC DATA ATTACHED:</b>                                                                                                                             |                |
| <input type="checkbox"/> Night Driving<br><input type="checkbox"/> Reading<br><input type="checkbox"/> Computer/Intermediate work<br><input type="checkbox"/> Sports<br><input type="checkbox"/> Other                                                                                                                               | <input type="checkbox"/> Auto-Refractor<br><input type="checkbox"/> Corneal Topography<br><input type="checkbox"/> OCT Scan<br><input type="checkbox"/> None |                |
| <b>PLEASE TICK PATIENT INTERESTS / SURGICAL GOALS</b>                                                                                                                                                                                                                                                                                |                                                                                                                                                              |                |
| <input type="checkbox"/> Premium IOL / Reduced Spectacle Dependence (Trifocal / EDOF / Toric)<br><input type="checkbox"/> Monovision / Blended Vision Strategy<br><input type="checkbox"/> Standard Monofocal (Distance or near) with Post-Op Spectacles<br><input type="checkbox"/> General Cataract Assessment / Medical Necessity |                                                                                                                                                              |                |

### REFERRING OPTOMETRIST

Name:

Practice Name

Provider Number:

Direct Phone/Email:

Signature:

Date:

☐ **FAST-TRACK REQUEST:** Tick this box to guarantee our team contacts your patient within 3 business hours and schedules an appointment within 3 days