



Cataract surgery referral form (page 1 of 2)

Please complete this form and ask either your optometrist or General Practitioner to make any further additions before forwarding it to CESP at your local office.

| | |
|---|--|
| Referral date | |
| Patient name | |
| Date of birth | |
| Patient address | |
| Patient telephone number | |
| Relative/friend contact details | |
| Telephone number | |
| Optometrist details | |
| Are you already on a waiting list for cataract surgery? (if so, where?) | |
| General Practitioner details | |

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This section to be completed by optometrist or General Practitioner

| | |
|----------------------------|--|
| Brief Ocular History | |
| Most recent Refraction | |
| Intra-ocular pressure | |
| Relevant medical history | |
| Other relevant information | |

Please sign and date:

Patient or relative Date.....

Optometrist Date.....

G.P Date.....

(it is not required to have your optometrist AND G.P. to sign)