

Eye and Ear Surgical Support (EESS) Program 2024-2025

Patient Information and Consent Form

Please complete all relevant sections and email completed form to vicoutreach@rwav.com.au. Please note that this form will be deemed ineligible if any required fields are left incomplete.

Referrer Details (Key Cont	act)	
Name of Referrer:		
Organization:		
Phone:		
Email:		
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Patient Details (any collai Patient Full Name:	lea data under EESS Wi	и ре ае-таетитеа)
Date of Birth:	Click orten to optor a de	***
	Click or tap to enter a da	ite.
Home Address:	Olasaasa sa itaasa	
MMM Location	Choose an item.	
Is the patient of Aboriginal and/or Torres Strait	☐Yes, Aboriginal	Yes, both Aboriginal and Torres Strait
Islander origin?	□No, Do Not Identify	Islander
		☐ Yes, Torres Strait Islander
mas the patient/parent/car	er signed the consent to	rm? Please see below Yes □ No □
Patient Consent for EESS I	Program Support	
l,	•	ient/Parent/Carer Name),
		gency Victoria (RWAV) with my name and
appointment information to	access Eye and Ear Surg	ical Support (EESS) Program.
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	· · · · · · · · · · · · · · · · · · ·	the within form will be used to assess eligibility
	• •	ram and for RWAV to undertake their duties in ustralian Government Department of Health,
		ividuals, agencies or organisations (e.g. local
	=	ecessary by RWAV to fulfil its obligations in the
administration of Outreach	•	occosary by rivery to rathens obtigations in the
	p. 08. a	
I further understand that this information will be kept confidential, in line with Rural Workforce		
Agency Victoria's Privacy Policy in accordance with The Privacy Act 1988, which governs collection,		
use, disclosure and security	of personal information.	
By completing this form and signing below, I give permission for RWAV to use the information		
provided in accordance with the confidentiality and privacy procedures as are set out in the policy statement that can be obtained from RWAV.		
statement that can be obtain	nea from KVVAV.	



PLEASE NOTE If you have any concerns in respect of this form, please email vicoutreach@rwav.com.au prior to signing the form.
Name:
Date:
Signed by Patient, Parent or Carer:
Please see attachment on original form
Patient Story
Short description on lifestyle limitations and why the surgery is needed:
Examples: Eyesight- Reducing the patient's ability to drive impacting their independence to visit family/friends.
Hearing: Child having reoccurring Otitis Media impacting their ability to learn new activities as they
cannot hear instructions
Procedure Details
□ Cataract -Please specify □ Left eye □ Right eye □ Both eyes

☐ Adenoidectomy (+/- tonsillectomy)
☐ Myringoplasty/tympanoplasty

☐ Grommets (Insertion of pressure equalizing tubes)

If <u>ear-related</u>, is surgery required as a result of Otitis Media? \Box Yes \Box No

Please specify \square Left ear \square Right ear \square Both ears

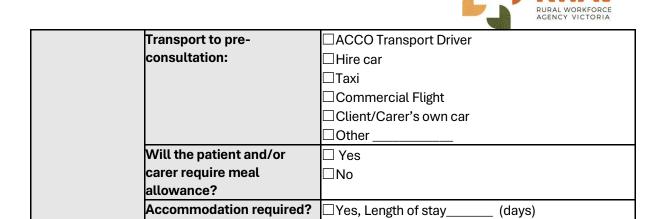
☐Myringotomy

☐ Other:

Ear Procedure



Date the patient w		Click or tap to enter a date.		
referred for surger	y by			
Specialist*:				
Is the patient		, hospital:		
currently on a pub waitlist?	lic No			
Please tick whether	er 🗆 Priv	· - 4		
this application is				
Private or Public		uc		
procedure?				
	_			
Stakeholder Det				
Anaesthetist name				
Practice/Clinic Na				
Primary Practice A	Address:			
Key Contact:				
Phone Number:			Email:	
Surgeon name:				
Practice/Clinic Na	ame:			
Practice/Clinic Ad	ldress:			
Key Contact:				
Phone Number:			Email:	
Hospital/Clinic:				
Practice/Clinic Na	ame:			
Practice/Clinic Ad	ldress:			
Key Contact (acco	ount/			
finance):				
Phone Number:			Email:	
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Pre-Consultation		- amountation our		-
Will the pallent re	-	consultation supp	Oft: Lites Lin	0
	Date of pro	e-consultation:	_	
			Click or tap to en	ter a date.
Pre-consultation	Location o	-		
details:	consultati			
	Will the pa		□Yes	
	_	nied by a parent or	LINU	
carer?				



□No

Surgery Details		
Will the patient re	equire <u>surgery</u> support? 🗆 Yes	s □ No
	Surgery date:	Click or tap to enter a date.
	Surgery Fees	□ Anesthetists Fees:
	Please provide individual	□Hospital Fees:
	quotes.	□Surgeon Fees:
	Will the patient be	□Yes
	accompanied by a parent or	□No
	carer?	
	Accommodation required?	□Yes, Length of stay (days)
Surgery Details:		□No
		□ACCO Transport Driver
	Transport:	□ Hire car
		□Taxi
		□Commercial Flight
		□Client/Carer's own car
		□Other
	Will the patient and/or	□Yes
	carer require meal	□No
	allowance?	

Post-Consultation	n Details	
Will the patient require post-consultation support? ☐ Yes ☐ No		
Date of post-consultation:		Click or tap to enter a date.
Post-consultation details:		
	Location of post-	
	consultation:	
	Will the patient be	□Yes
	accompanied by a parent or	□No
	carer?	
	Transport to post-	☐ACCO Transport Driver
	consultation:	□Hire car



	□Taxi
	□Commercial Flight
	☐ Client/Carer's own car
	☐ Other
Will the patient and/or	□Yes
carer require meal	□ No
allowance?	
Accommodation required?	\square Yes, Length of stay (Days)
	□No

	Rural Workforce Agency Victoria Use Only
Total Estimated Cost	Pre-consultation costs:
for Patient Support	
(Please list applicable	Surgery costs:
support for travel,	
meal,	Travel:
accommodation, and	
surgery)	Total KM =
	Accommodation:
	Meals:
	Breakfast
	Lunch
	Dinner
	Total:
	Post-consultation costs:
Patient Surgery Supp Surgical Support (EES EESS Patient number	
Assessed by:	
Date:	
Approved by:	
Date:	

