Eye and Ear Surgical Support (EESS) - Application Form January – June 2024

Please complete all relevant sections and submit to RWAV a minimum of **30 days prior** date of surgery.
Email completed form to Vicoutreach@rwav.com.au

Referrer Details *(Key Contact)*	
Name of Referrer:	
Organisation:	
Phone:	
Email:	

Patient Details *(any collated data under EESS will be de-identified)*	
Patient Full Name:	
Date of Birth:	
Home Address:	
MMM Location	Choose an item.
Is the patient of Aboriginal and/or Torres Strait Islander origin*?	☐ Yes, Aboriginal ☐ Yes, both Aboriginal and Torres Strait Islander ☐ No, Do Not Identify ☐ Yes, Torres Strait Islander
Has the patient/parent/carer signed the consent form on page 4*? Yes ☐ No ☐	See attached

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

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Stakeholder Details			
Hospital/Clinic:			
Address:			
Key Contact:			
Phone Number:		**Email:**	

Surgeon Name:			
Practice/Clinic Name:			
Practice/Clinic Address:			
Phone Number:		**Email:**	

Anaesthetist Name:			
Practice/Clinic Name:			
Practice/Clinic Address:			
Phone Number:		**Email:**	

Procedure Details	
Eye Procedure	☐ Cataract -Please specify ☐Left eye ☐Right eye ☐Both eyes ☐ Other:
Ear Procedure	☐ Adenoidectomy (+☐ tonsillectomy) ☐ Myringoplasty/tympanoplasty ☐ Myringotomy ☐ Grommets (*Insertion of pressure equalizing tubes)* Please specify ☐Left ear ☐Right ear ☐Both ears ☐ Other:
	If <u>ear-related</u>, is surgery required as a result of Otitis Media? * ☐ Yes ☐ No
Date the patient was referred for surgery by Specialist*:	
Is the patient currently on a public waitlist?	☐ Yes, hospital: ☐ No
Please tick whether this application is for <u>Private</u> or <u>Public</u> procedure?	☐ Private ☐ Public

Level 6, Tower 4, World Trade Centre,
18 – 38 Siddeley Street, Wurundjeri Country
Melbourne, VIC 3005, Australia

P: 03 9349 7800
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www.rwav.com.au

Pre-Consultation Details
Will the patient require pre-consultation funding support? ☐ Yes ☐ No

Surgery Details		
Will the patient require surgery funding support? * ☐ Yes ☐ No		
Surgery Details:	**Surgery date*:**	
	Surgery Fees ***Please provide individual quotes.*** *	Service / Provided quote / Cost Anaesthetists Fees: Yes ☐ Hospital Fees: Yes ☐ Surgeon Fees: Yes ☐ Other associated costs. Yes ☐
	Will the patient be accompanied by a parent or carer?	☐ Yes ☐ No
	Accommodation required?	☐ Yes, Length of stay_____ ☐ No
	Transport:	☐ ACCO Transport Driver ☐ Hire car ☐ Taxi ☐ Commercial Flight ☐ Client/Carer's own car ☐ Other _____
	Will the patient and/or carer require meal allowance?	☐ Yes ☐ No

Post-Consultation Details
Will the patient require post-consultation funding support? * ☐ Yes ☐ No

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Patient Consent for EESS Program Support

I, _____ (Patient/Parent/Guardian),
hereby give my consent to provide Rural Workforce Agency Victoria (RWAV) with the patient details such as name, date of birth and appointment information to access Eye and Ear Surgical Support (EESS) Program.

I understand that the Patient information provided in the within form will be used to assess eligibility for funding and/or support from the EESS program. RWAV will use the information to undertake their duties in the administration of EESS program, including the Australian Government Department of Health, the Victorian Advisory Forum and other individuals, agencies or organisations (e.g. local health providers) as required by law or as deemed necessary by RWAV to fulfil its obligations in the administration of EESS program. All data will be deidentified when sharing with external organisations for reporting purposes.

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.

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, guardian, parent or carer: _____

Witness/ Health Worker Name: _____

Date: ___/____/_____

Signed: _____

Please see attachment on original form

End of form

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Rural Workforce Agency Victoria Use Only	
Total Estimated Cost for Patient Support *(Please list applicable support for travel, meal, accommodation, and surgery)*	Pre-consultation costs: Surgery costs: Anaesthetists Fees: Surgeon Fees: Hospital Fees: Total cost $ Post-consultation costs:

Patient Surgery Support Approval by Rural Workforce Agency Victoria under the Eye and Ear Surgical Support (EESS) Program

EESS Patient number:	
Assessed by:	
Date:	

Approved by:	
Date	

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