DRAFT

vision assessment referral

Name Date of Birth / /

Address

Referred for:

- ☐ Flashes/Floaters
- ☐ Headaches or Eyestrain
- ☐ Sore Eye/Red Eye
- ☐ Dry eyes
- ☐ Reduced vision at distance
- ☐ Reduced vision at near
- ☐ Current optical correction inadequate
- ☐ Other

Optometric Services:

- ☐ General checkup
- ☐ Diabetic review
- ☐ Driving assessment
- ☐ Children's vision assessment
- ☐ Contact lens fitting
- ☐ Specialty contact lens fitting
- ☐ Anterior eye examination
- ☐ Retinal examination/photography
- ☐ Visual fields assessment
- ☐ Occupational vision assessment
- ☐ Retinal/fundus photography
- ☐ Other

Report Required? Y ☐ N ☐

Medication list attached? Y ☐ N ☐

Comments / other significant health issues

Referrer's Name

Signature Date / /

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