



REFERRAL TO OPHTHALMOLOGIST

Referring Practitioner _____ Date: _____

Prov. No: _____

Dear Michael

Could you please see and assess:

PATIENT: Name: _____ D.O.B: _____
Address: _____
Phone No. _____

PROBLEM:

EXAMINATION:

Right Eye

VA R _____ u/a
R _____ with glasses

Subjective Refraction

R _____

IOP

R _____ mm Hg

Left Eye

VA L _____ u/a
L _____ with glasses

Subjective Refraction

L _____

IOP

L _____ mm Hg

ANT SEG:

POST SEG:

Regards _____ Referral valid for: 3 Months 12 Months other
Signature