



## REFERRAL TO OPHTHALMOLOGIST

**Referring Practitioner** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ **Prov. No:** \_\_\_\_\_

Dear Andrew

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

**ANT SEG:**

**Left Eye**

VA L \_\_\_\_\_ u/a  
 L \_\_\_\_\_ with glasses

**Subjective Refraction**

L \_\_\_\_\_

**IOP**

L \_\_\_\_\_ mm Hg

**POST SEG:**

Regards \_\_\_\_\_ Referral valid for: 3 Months  12 Months  other   
 Signature