

# Referral Form

Name: ..... Date of Birth: .....

Address: .....

..... Postcode: ..... Telephone: .....

## Ocular and Related Medical Condition

Diagnosis: .....

Prognosis                      Stable                       Progressive

Onset: .....

Current Medications: .....

.....

Other Relevant Medical Conditions: .....

.....

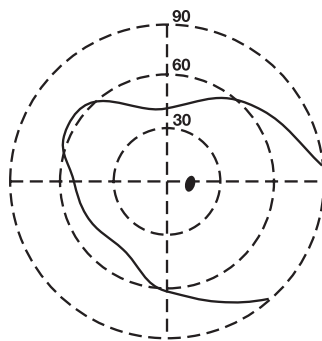
## Current Visual Status (details of recent refraction within preceding 6 months)

Visual Acuity:	Unaided Distance	R _____	L _____
	Aided Distance	_____	_____
	Near	_____	_____

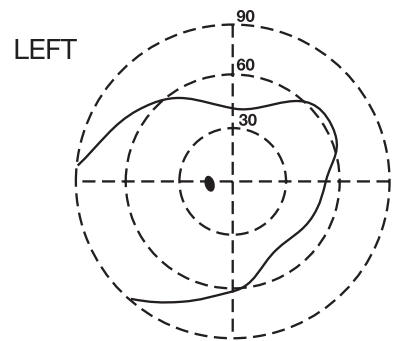
Present Glasses	Sphere	R _____	L _____
	Cylinder	_____	_____
	Axis	_____	_____
	Add	_____	_____

Present Refraction	Sphere	R _____	L _____
	Cylinder	_____	_____
	Axis	_____	_____
	Add	_____	_____

Indicate any visual field defect (if significant defect please enclose computerised field).



RIGHT



LEFT

Comments

.....  
.....

Please either stamp or print Practitioner's name & address in full.

.....  
..... Signed: .....  
..... Date: .....  
.....

**FOR OFFICE USE ONLY**