



Dear Dr Anil Sharma,

Date of Referral: _____

Patient Information:

Name: _____

Postal Address: _____

DOB: _____

Phone (H) _____ (M) _____

Please assess this patient regards to:

- | | |
|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Continued Care | <input type="checkbox"/> Capsular Opacification |
| <input type="checkbox"/> Pterygium | <input type="checkbox"/> Lid Anomaly |
| <input type="checkbox"/> Anterior Segment | <input type="checkbox"/> Other _____ |

Relevant Details:

Refraction: R) _____ L) _____

VA: R) _____ PH _____ L) _____ PH _____

IOP: R) _____ L) _____ at _____ am/pm on _____

Perimetry/Photographs/Other Investigations:

- Attached Emailed Faxed

Other Details: _____

Referring Optometrist:

Optometrist Name: _____ Provider No. _____

Location: _____

Signed: _____