Referral Form

Patient Name: _________________________ DOB: _______ Date of Exam: ______

I am referring the above patient to ______________________ for the following:

☐Cataract Evaluation	☐Foreign Body
☐Glaucoma Evaluation	☐Flashes/Floaters
☐Diabetic Evaluation	☐Loss of Vision
☐Other : _______________________________	

Ocular findings:

VAsc	OD: 20/ ____	VAcc	20/ ____	NVcc	J ____	IOP	____
	OS: 20/ ____		20/ ____		J ____		____

Original Rx:	OD __________ x ____	OS __________ x ____ = 20/ ____
Present Rx:	OD __________ x ____	OS __________ x ____ = 20/ ____
Manifest Rx:	OD __________ x ____	OS __________ x ____ = 20/ ____

SLE:	**OD**	**OS**
Conjunctiva:	White & quiet / _______________	White & quiet / _______________
Cornea:	Clear/ _______________________	Clear/ _______________________
AC:	Deep/mod/shallow/ ____________	Deep/mod/shallow/ ____________
Lens:	Clear/___ NS/___PSC/___Cort.	Clear/___ NS/___PSC/___Cort.

EOM _________________________________**Confrontation fields** ____________________________

FUNDUS: ________________________________ ____

CURRENT EYE MEDICATIONS: ____

____

ASSESSMENT:

1.____

2.____

3.____

PLAN OR REQUEST:

1.____

2.____

** Please include Visual Fields if appropriate

___________________________________ ___________________________________

Optometrist Signature Optometrist (Please Print Name)