CATARACT / CLE DIRECT REFERRAL FORM

MIDLAND EYE
PRIVATE CLINIC

Surname:	Forename(s):	Title:
Occupation:	Date of Birth:	Male ☐ Female ☐
Address:	Home Tel. Number:	
	Mobile Number:	

Referral is for: First Eye ☐ Second Eye ☐ Right Eye ☐ Left Eye ☐

CURRENT REFRACTION		**VA**	**Pinhole**	**Sph**	**Cyl**	**Axis**	**Prism**	**Add**	**NVA**
Date	**R**								
Dispensed **YES / NO**	**L**								

PREVIOUS REFRACTION		**VA**	**Pinhole**	**Sph**	**Cyl**	**Axis**	**Prism**	**Add**	**NVA**
Date	**R**								
	L								

EYE EXAMINATION		**Disc + C/D**	**IOP NCT/APP**	**ARMD NO/SI/MOD/SEV**
Date				
	R			
Dilated **YES / NO**	**L**			

Notes / Comments:

REFERRING OPTOMETRIST		**GENERAL PRACTITIONER**	
Name **Address** **Tel No.**		**Name** **Address** **Tel No.**	
Signed	**Date:**	**Patients signature**	**Date:**
Any Additional Information:			

Fax to Midland Eye on 0121 711 4040