Comprehensive Eye Examination Referral Letter

Name ____________________

Date of birth ____________________

School ____________________

Primary Care Provider ____________________

Date of examination ____________________

Findings:

Visual Acuity	OD	OS
Uncorrected		
Best corrected		

	Normal		Abnormal (describe)
	OD	OS	
Color vision			
Ocular motility			
Pupils			
Anterior segment			
Fundus			
Stereopsis			
Accommodation and convergence			

Diagnosis:

Normal exam   Myopia   Hyperopia   Astigmatism   Amblyopia

Strabismus (describe) ____________________

Other ____________________

Glasses prescribed?   No   Yes (cycloplegic refraction) ____________________

Treatment plan ____________________

Treatment duration ____________________

Medications used ____________________

Prognosis ____________________

Optometrist/Ophthalmologist (print) ____________________

Signature ____________________ Date ____________________

Address ____________________