

OPTOMETRY REFERRAL FORM

Patient:
Address:

NHI:

DOB:

Dear Optometrist

Please assess this patient for:

- Cataract
- Possible glaucoma
- Headaches
- Sore and/or red eye
- Compliance with visual standards
(e.g. driving, police, occupational)
- Presbyopia
- Suitability of current spectacle Rx
- Recent change in vision
- Other (please specify)

Please contact patient to arrange an appointment

OR

Patient to arrange appointment

Please provide a report of your findings

Signed: _____

GP Name:
Practice :

(or Practice Stamp)

(complete if specific optometrist required)

Optometrist:
Practice :

Relevant background details are:

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Current medications include:

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N·Z·A·O

NEW ZEALAND ASSOCIATION
OF OPTOMETRISTS INC.