

Private referral for Contact Lens Assessment/After-Care

To: Mr Andrew D Price FBDO(Hons)CL, COA

PLEASE USE CONFIDENTIAL FAX NUMBER:

01244 421126

or EMAIL: patients@adp-eyecare.co.uk

or provide to patient to bring to appointment

Date:

Copies to: Patient File GP

Sent: via post by hand with patient fax e-mail

Patient title:

Surname, Name(s):

Address:

Postcode:

Date of Birth:

Telephone:

Mobile:

Email:

If referring from Optician/Optomtrist – optional spectacle and/or contact lens Rx from last eye/contact lens exam, however BCVA please. If pharmacy or non-eye clinic leave blank.

Spec/CL Rx R

BCVA

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BCVA

Chief Ocular Complaint(s), especially relating to contact lens wear/reason for referral:

Patient Ocular Hx, especially relating to contact lens wear:

Gross examination and/or bio-microscope* exam (*if pharmacy/non-eye clinic not applicable) signs:

Relevant details of PMHx history (inc meds & supplements):

(Check if *appropriate*):

- The patient has consented to sharing this information with you and that you will not further share with others without his/her express permission.
- I have included other eye exam results if appropriate/available
- I have explained this will be a private fee-for-service assessment and/or I would like you to explain fully your charges to the patient before an appointment is arranged

• I understand you will address this patients contact lens needs only and will then refer back to me for all other eye-care/health-care needs, including if appropriate; spectacle dispensing, contact lens care and routine eye health product purchase along with a written report on your findings and management.

Signed:

Date:

Eye Care/Health Care Professional's name and qualifications:

Practice/Pharmacy/Clinic address:

Tel:

E-mail:

Other notes: