re:vision
Anterior Segment Specialists

Please fax this to **09 222 2021** or email to **reception@re.vision.nz**

Dr / Mr / Mrs / Ms / Miss *(circle)* DOB ______________________

Patient Name ____

Address ____________________________________ Postcode ____________

Phone - Work ________________ Home ________________ Mobile ________________

Email ____

Presenting Problem ____

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Referred to

◯ Dr Trevor Gray ◯ Dr Mo Ziaei ◯ First available

Thank you for seeing my patient for assessment of

◯ Cataract
◯ Cornea
◯ Dry Eye
◯ Implantable Contact Lenses (ICL)
◯ Laser Vision Correction
◯ Refractive Lens Exchange
◯ Other

Please State ______________________

Comments ____

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(PTO for further comments)

Refraction (R) 6/ (L) 6/
Add+ N Add+ N

Appt made ◯ Yes Date ______________________ ◯ No Re:Vision to contact patient

Referring Optometrist

Optometrist Name ______________________

Signed ______________________

Date ______________________

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