

Surname	Title	Date of birth (if under 16)
Other names		Date of examination
Address		Ref. number
Postcode		

R I G H T	Sph.	Cyl.	Axis	Prism	Base	Dist. Near	Sph.	Cyl.	Axis	Prism	Base	L E F T
	Other prescription (if required) to be used for*:											

BVD (if needed)	
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\*e.g. VDU or intermediate.

OTHER INFORMATION: \_\_\_\_\_

NAME AND ADDRESS OF OPTOMETRIST'S PRACTICE:

I have today conducted an eye examination on the above-named, in accordance with all the appropriate Regulations, with the following result:

- |   |  |
|---|--|
| <input type="checkbox"/> Prescription as above.   | <input type="checkbox"/> No change from present prescription is necessary. |
| <input type="checkbox"/> No prescription advised. | <input type="checkbox"/> Referred to doctor.                               |

Date: \_\_\_\_\_ Re-examination advised in \_\_\_\_\_ months.

Optometrist:

Name (CAPITALS): \_\_\_\_\_

Signature: \_\_\_\_\_

GOC No. \_\_\_\_\_

Address at which sight test was carried out/name and address of practice where fitting was done, if different from practice address above: \_\_\_\_\_