Patient Record

Date	Refractionist name	Patient code	Data entered to PC? ☐ Y
Family Name	Given Name	Date of birth Adult ☐ Child (<18yrs) ☐	**Referred From**
Address	Phone	Gender M / F	☐ No Referral ☐ Disability Services ☐ Secondary/Tertiary Eye Care Services
Date of last eye examination:	Occupation:		☐ Non-Ophthalmic Medical Services

History

Past Ocular History:

General Health: HTN / DM / Asthma, Other_____

Family History: Glaucoma, Cataract / DM / HTN/ Other_____

☐ Community/School Screening
☐ Health Promotion
☐ Word of Mouth

Disability: Y / N

Diabetes: Y / N

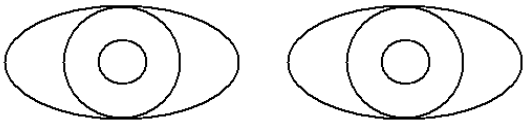
Select One: Full Eye Exam (FE) / Short/Partial Eye Exam (SP) / Screening (S) / Low Vision (LV)

Unaided	**Pinhole**	**Current Spectacles**	**Vision**	**Retinoscopy**	**Vision**
R	R	R	/	R	/
L	L	L	/	L	/
Near		Add	Date prescribed:		
		SVD SVN B/F RMS			

Subjective Refraction	**Vision**	**Final Prescription**
R	/	**R**
L	/	**L**
Add		**Add**
		Rx Given: SVD / SVN / BIFOCAL / RMS / LVA

Eye Health **R** **L**

Slit Lamp



Ophthalmoscopy **R** **L**

Management

Referral Y / N **DS** (disability services) **ST** (secondary/tertiary eyecare services) **MS** (Non ophthalmic medical services)

Frame Details	Frame Price	**Lens Type**	Seg Height	Lens Price	**Total Price**
Brand/ Model / Colour		Material R L	**PD** (D / N)		

Payment Details	Payment 1	Payment 2	Payment 3	Payment 4
Amount		Amount	Amount	Amount
Type		Type	Type	Type
Date		Date	Date	Date
Receipt #		Receipt #	Receipt #	Receipt #
Balance		Balance	Balance	Balance