

VISION EXAMINATION REPORT

(All sections must be completed)

SECTION A – PARTICULARS OF THE EXAMINEE

Name	Date of Birth (DD/MM/YY)	Sex
Examination Date (DD/MM/YY)	Policy No.	
If group insurance, name of the Policy Holder		

SECTION B – EXAMINING OPTOMETRIST'S REPORT

1.	Please describe general condition of eyes		
2.	Other abnormalities or observations: please specify		
3.	Report on Vision Examination (as per symbols shown)		
Visual Acuity	O.S.	=	O.D. =
Refraction Assessment	O.S.	=	O.D. =
Tonometry	O.S.	=	O.D. =
Cornea	O.S.	=	O.D. =
Conjunctiva / Pterygium	O.S.	=	O.D. =
Lens / Cataract	O.S.	=	O.D. =
Retina	O.S.	=	O.D. =
Optic Disc	O.S.	=	O.D. =

Name of Optometrist: _____

Address: _____

Telephone No.: _____

E-mail: _____

Signature of Optometrist

Date: _____