Dry Eye Doctor

Referral Form

First name: _____ Last name: _____

DOB: ____/____/_____ Telephone: _____

Address: _____

_____

_____

Symptoms:

Burning ☐ Grittiness ☐ Itching ☐

Variable vision ☐ Pain around eyes ☐ Foreign body sensation ☐

Other symptoms: _____

_____

_____

Relevant medical history: _____

_____

_____

Referer details: _____

GP / Optom / Ophthal _____