Dr Season Yeung

MBBS, MMedSci, FRANZCO
Ophthalmologist and Ophthalmic Surgeon
Cataract, Cornea, External Diseases, Refractive Surgery & General Ophthalmology

Name of Patient: _____

Date of Birth: _____

Address: _____

Reason for Referral

- ☐ Cataract Assessment
- ☐ Decreased Vision
- ☐ Dry Eyes
- ☐ Foreign Body
- ☐ Laser Vision Correction
- ☐ Pterygium
- ☐ More Referral Pads
- ☐ Chalazion/Lid lesions
- ☐ Diabetic Eye Review
- ☐ Eye Trauma
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Sudden loss of Vision
- ☐ Others:

_____

_____

_____

_____

_____

Refraction (if appropriate)

Right Eye _____ Left Eye _____

Referring Doctor / Optometrist Information

Name:

Provider no:

Address:

Telephone:

Email:

Signature _____ **Date** _____