

EYE CARE MEDICAL PRACTITIONER FORM

PARTICULARS OF CLIENT

Name: _____

Address: _____

E-Mail address: _____

Telephone number: _____

Identity number: _____

PARTICULARS OF MEDICAL PRACTITIONER

Name _____ (practice or HPCSA No) _____

Address _____

E-Mail address _____

Telephone number _____

I _____ (medical practitioner's full name), identity number
_____ and practice number or HPCSA number _____ do hereby
declare the following:

1. I am a qualified medical practitioner and qualified and practicing specialist in
_____ (state area of speciality)
2. I have examined _____ (state practitioner's
name and identity number) on _____ (date)

3. Consent has been given to me by the client/patient to disclose the findings made with respect to the examination.
4. Short summary Case History. (Relating to visual)

5. Relevant findings (Visual)

Unaided VA OD _____ OS _____ OU _____

Aided VA OD _____ OS _____ OU _____

Visual Fields (Screening) OD _____ OS _____

Other pertinent findings _____

6. Professional opinion and recommendations (Treatment/management suggestions and prognosis. Include suggested follow-up)

I confirm that the above and the attached documentation are a true and correct reflection of the condition suffered by _____ (state practitioner's name)

_____ (Name)
_____ (Signature)
_____ (Date)

PRACTITIONER'S STAMP.

Please note the following:

1. The **document or attached report should be written within the past 2 years.**
2. The document or attached report must be printed on the practitioner's official letterhead