Eye Examination Report

[Please ensure that this report form is filled in by a licensed medical practitioner. You can send in the report To us by email at _____ or post it to us.]

Name of patient	SSN#
Date of Birth	
Address	
City/Town:	State
Zip	
Sex	
Medical card number	

1Best vision score achieved by patient in Snellen Test:

Right eye: _____ Examination date [dd/mm/yy]:_____

Left eye: _____ Both eyes: _____

2. Requirements for patient in order to achieve a Snellen Test score of 20 upon 40: [Tick the correct option]

☐Corrective Lenses for Left Eye ☐Corrective Lenses for Right Eye ☐Corrective Lenses for both

3. The eye examination report is valid till: _____[dd/mm/yy]

Name of eye examiner	Associated with
Address	

City/Town	State
ZIP	

Declaration: *I have examined the patient for signs of eye related disorders and malfinctions carefully and in accord with the practices of my profession. I take responsibility for the accuracy of this report.*

Signature of examiner	
Signature of patient	
Date	