Refraction Form

Patient Name	:	sai krishna				Emirates ID	:	784-8666-6666666-7
File No	:	8	DOB	:	1996-09-25	Nationality	:	Other
Gender	:	Male	Doctor's Name	:	Opthalmology Doctor	Date	:	2024-04-23

Visual Acuity

TYPE:

OD: PH: : GLS: CL:

OS: PH: : GLS: CL:

Pachymetry

OD:um.

OD:um.

Glasses Prescription

Glass1: um.

Glass2: um.

Dominant Eye ☐ OD ☐ OS

Subjective1/1/1900 12:00:00 AM

OD Sph Cyl; Axs VA ADD Va PH: Remarks

OD Sph Cyl; Axs VA ADD Va PH: NAME Remarks

Cylco1/1/1900 12:00:00 AM

OD Sph Cyl; Axs VA ADD Va PH: Remarks

OD Sph Cyl; Axs VA ADD Va PH: NAME Remarks

Dry Test1/1/1900 12:00:00 AM

OD Sph Cyl; Axs VA ADD Va PH: Remarks

OD Sph Cyl; Axs VA ADD Va PH: NAME Remarks dfg

Auto Refraction Photo

Cyclo Photo

Dry Test Photo

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
Patient Name sai krishna Date 2024-04-23 (12:45 - 13:00)	Doctor Name Opthalmology Doctor - Ophthalmology (Oph45) Date 2024-04-23 (12:45 - 13:00)