

REFERRAL REFINEMENT CONSENT FORM

Patients Name: Address:	Optometrist Name: Address:
D.o.B:	Tel No:
Tel No:	Contractor's Number: Co-

PATIENT DECLARATION

I certify that I have attended a second appointment.
I certify that I have had further tests carried out and the results have been explained to me.
I am aware that these results may be used for auditing purposes.

Name (please print):	
Signature:	Date:

Please retain this completed form. Sight of this may be requested by the tPCT.