re:vision
Laser & Cataract

Please fax this to **09 222 2021** or email to **reception@re.vision.nz**

Dr / Mr / Mrs / Ms / Miss *(circle)* DOB _____

Patient Name _____

Address _____ Postcode _____

Phone - Work _____ Home _____ Mobile _____

Email _____

Presenting Problem _____

Referred to

◯ Dr Trevor Gray ◯ Dr Mo Ziaei ◯ First available

Thank you for seeing my patient for assessment of

◯ Cataract
◯ Cornea
◯ Dry Eye
◯ Implantable Contact Lenses (ICL)
◯ Laser Vision Correction
◯ Refractive Lens Exchange
◯ Other

Please State _____

Comments _____

(PTO for further comments)

Refraction (R) 6/ Add+ N (L) 6/ Add+ N

Appt made ◯ Yes Date _____ ◯ No Re:Vision to contact patient

Referring Optometrist

Optometrist Name _____

Signed _____

Date _____

Re:Vision Laser & Cataract
6C Pacific Rise, Sylvia Park, Mt Wellington, 1060
Free : 0800 55 20 20
P : 09 222 2020
F : 09 222 2021
E : reception@re.vision.nz
W : www.revision.nz