Spectacle telephone review

Patient name:		Patient identifier:	
Date of birth:		Practitioner:	
		Date of last sight test:	

Existing lens type:	
Additional notes to confirm the need of the telephone consultation:	

Existing spectacle prescription			
Right:		PD Heights	Previous VA
Left:		PD Heights	Previous VA

Telephone consultation

Do you have current concerns about your spectacles or eye health?	
How is your vision when wearing spectacles?	
Any other questions?	
How is the comfort of your spectacles?	
How many hours a day do you wear your spectacles for?	
Do you wear spectacles for driving?	

Have you experienced any of the following?	
Double vision:	-
Blurred vision:	-
Light sensitivity:	-
Eye pain:	-
Headaches:	
General health:	

Recommendations

Details of spectacles supplied:	Date when sight test recommended?
Remind patient if spectacles do not perform as expected, they should remove them and contact practice.	
Other notes:	
Signature: GOC:	Date: