DR NAING L TINT
CATARACT, LENS AND LASER EYE SURGEON

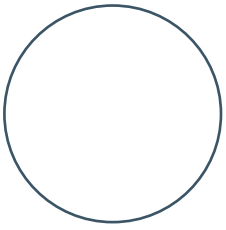
Optometrist Referral Form

Referral for Dr Naing L. Tint: Prefered Location Breahead Clinic (Glasgow)

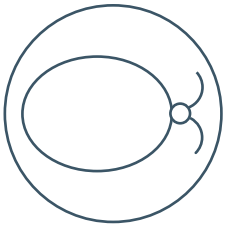
Patient Details	Referral Type:	Referring Optometrist Details:
Name: _____	☐ Cataract ☐ Refractive	Name of Practice: _____
DoB: _____	☐ Cornea ☐ Glaucoma	Name of Optometrist: _____
Address: _____	☐ Surgical Retina ☐ Medical Retina	Address: _____
_____	☐ Oculoplastics	_____
Email: _____	☐ Other: _____	Email: _____
Postcode: _____	Date of referral: _____	Postcode: _____
Tel: _____		Tel: _____

RIGHT

Corneal

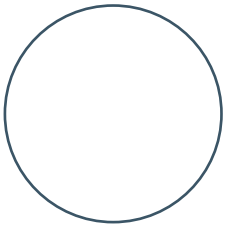


Fundus

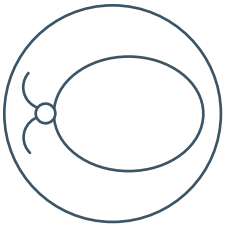


LEFT

Corneal



Fundus



To draw on the above diagrams, select 'Comment' from your toolbar, then choose the Pen Icon.
Click here for additional information if necessary.

Visual Acuity	Right eye: Distance		Near	Left eye: Distance		Near
Spectacle Prescription	SPH	CYL	AXIS	SPH	CYL	AXIS
I.O.P	Non Contact / Contact			Non Contact / Contact		

Additional Information / Comments:

☐ Copy of visual fields attached
☐ Copy of OCT attached

Optometrist to upload this form to the Eye Surgery Scotland website referral page.

https://www.eyesurgeryscotland.com/clinical-referral-form

Please retain a copy for your records. Following submission, a confirmation email will be returned to your address. If you do not receive this within 24 hours of submission please contact admin@eyesurgeryscotland.co.uk

Please click for conformation: I have the patients permission to retain their medical information and share it with Eye Surgery Scotland for clinical and medical useThe patient will not be contacted without their consent for any other reason than in follow up of their ongoing medical care and long term health benefits. ☐