



## PRACTITIONERS FORM (VISUAL IMPAIRMENT)

## **PARTICULARS OF CLIENT**

Name:			
Addres	s:		
E-Mail	address:		
Teleph	one number:		
Identity	number:		
PARTI	CULARS OF MEDICAL PRACTITIO	DNER	
Name_	(pra	actice or HPCSA No)	
Addres	s		
E-Mail	address		
Teleph	one number		
I	(m	nedical practitioner's full name), i	dentity number
	and practice the following:		
1.	I am a qualified medical practitione	er and qualified and practicing sp	
2.	I have examined		(state practitioner's
	name and identity number) on	(date)	

3.	Consent has been given to me by the client/patient to disclose the findings made with respe-				
	to the examination.				
4.	4. Short summary Case History. (Relating to visual)				
5.	Relevant findings (Visual)				
	<u>Unaided</u> VA OD OS OU				
	<u>Aided</u> VA OD OS OU				
	Visual Fields (Screening) ODOS				
	Other pertinent findings				
6.	Professional opinion and recommendations (Treatment/management suggestions and				
	prognosis. Include suggested follow-up)				

I confirm that the above and the attached documentation are a true and correct reflection of the				
condition suffered by		(state practitioner's name)		
	(Name) (Signature) (Date)	PRACTITIONER'S STAMP.		

Please note the following:

- 1. The document or attached report should be written within the past 2 years.
- 2. The document or attached report must be printed on the practitioner's official letterhead