



Vancouver Island + Metro Vancouver | www.outreachoptometry.ca
phone: 250-591-1072 | fax: 250-591-1006 | hi@outreachoptometry.ca

Mobile Eye Exam Request

Date	Patient Name	DOB
Referred By	Contact Info: Parent/Guardian/Hospital/Agency	
Address	Address	
City	Province	Postal Code
Phone	Phone	

Pertinent Symptoms/ History:

Important: Please fax a copy of your results of the exam if available

Eyeglass Rx	OD	VA OD
	OS	VA OS

I hereby grant permission for Outreach Optometry to exchange information regarding my case, history, results of examination, diagnoses, treatment etc. I hereby give permission to have this information faxed to Outreach Optometry so that their office may contact me to schedule an appointment.

Patient/Parent Signature	Date	Doctor Signature
--------------------------	------	------------------