

Dispensing Authority

PATIENT NAME:

ADDRESS:

Unit, number, and street name

City

Province

Postal code

DATE OF REFRACTION:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

	Sphere	Cylinder	Axis
O.D.			
O.S.			
ADD POWER			
OTHER INFORMATION:			

I have conducted an automated refraction on the above-named patient, in accordance with the *Ethics and Practice Standards*, with the following result:

- Assessment record as recorded above
- No assessment record was produced
- Referred to a prescriber

Name and address of Licensed Optician's practice:

OPTICIAN NAME:

OPTICIAN SIGNATURE:

OPTICIAN LICENCE #: