Certificate

1. Patient's full name and surname :
2. Patient's postal address :

3. Patient's ID number & signature :

Signature:

4. Optometrist's full name and surname :

5. Practice physical address :

Tel Nr:

6. HPCSA registration number :

Practice Nr:

7. Indicate the level of acuity & visual field by marking the appropriate vacant space (box)

RIGHT EYE

	6/60	6/36	6/24	6/18	6/12	6/9	6/9+	6/7.5	6/7.5+	6/6	6/6+	6/5+
Snellen rating in meters	6/60	6/36	6/24	6/18	6/12	6/9	6/9+	6/7.5	6/7.5+	6/6	6/6+	6/5+
Snellen rating in feet	20/200	20/100	20/60	20/50	20/40	20/30	20/30+	20/25	20/25+	20/20	20/20+	20/15
Decimal notation	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1	1.1	1.2
Acuity With glasses/contact lenses												
Acuity Without glasses/contact lenses												

Actual horizontal temporal field	0° to 69°	°
*	70° +	°

* Degrees MUST be specified

Actual horizontal total field	less 115°	°
*	115° +	°

* Degrees MUST be specified

LEFT EYE

	6/60	6/36	6/24	6/18	6/12	6/9	6/9+	6/7.5	6/7.5+	6/6	6/6+	6/5+
Snellen rating in meters	6/60	6/36	6/24	6/18	6/12	6/9	6/9+	6/7.5	6/7.5+	6/6	6/6+	6/5+
Snellen rating in feet	20/200	20/100	20/60	20/50	20/40	20/30	20/30+	20/25	20/25+	20/20	20/20+	20/15
Decimal notation	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1	1.1	1.2
Acuity With glasses/contact lenses												
Acuity Without glasses/contact lenses												

Actual horizontal temporal field	0° to 69°	°
*	70° +	°

* Degrees MUST be specified

Actual horizontal total field	less 115°	°
*	115° +	°

* Degrees MUST be specified

Issued without alterations

I, the undersigned, acknowledge that the information recorded is truthful and complete and official identification confirmed.

_____ Signature of Optometrist

_____ Date of screening

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South African Optometric Association
Your Custodian of the Profession