INFORMED REFUSAL — DILATION

I, _____ have been informed on this date by my optometrist of the need for a dilated
(PRINT NAME)
examination of my eyes. It has been explained to me and I understand that a condition with the potential for partial or total loss of vision may exist and without dilation it may go undetected.
Being advised of the above, I hereby decline to have my eyes dilated.

_____ _____ ___/___/___
(O.D. SIGNATURE) (PATIENT SIGNATURE) DATE

_____
(O.D. NAME PRINTED)

INFORMED REFUSAL — TONOMETRY "GLAUCOMA TEST"

I, _____ have been informed on this date by my optometrist of the need for an eye
(PRINT NAME)
pressure test to screen for glaucoma. I have been informed and understand that if I have glaucoma and a pressure test is not performed, the disease may be undetected with the potential for a partial or total loss of vision. I have also been informed of the various means by which my eye pressure may be tested. Being advised of the above, I hereby decline an eye pressure test.

_____ _____ ___/___/___
(O.D. SIGNATURE) (PATIENT SIGNATURE) DATE

_____
(O.D. NAME PRINTED)