MILTON EYE SURGEONS | HALTON RETINA CENTRE

# PATIENT REFERRAL FORM

Please fax to **905-876-5083** or email to
contact@miltoneye.com or contact@haltonretina.com

☐ Dr. Aaron Chan
- Cataract
- Medical Retina
- Glaucoma

☐ Dr. Nour Nofal / Dr. Ore Erikitola
- Cornea
- Cataract
- Complex Ant Seg

☐ Dr. Shaobo Lei
- Medical Retina
- Surgical Retina
- Cataract (private only)

☐ No Preference

## REFERRING DOCTOR

Referring Doctor: _____ Billing #: _____

Address: _____ City: _____ Postal Code: _____

Office Phone #: _____ Fax #: _____

## PATIENT INFORMATION

Last Name: _____ First Name: _____

OHIP #: _____ Version Code: _____ DOB (dd/mm/yyyy): _____ / _____ / _____ Sex: _____

Address: _____ City: _____ Postal Code: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Urgency of Referral:

☐ Urgent ☐ Elective

Location Preference:

☐ Milton Clinic ☐ Oakville (OTMH)

| Exam | OD | OS |
|---|---|---|
| Visual Acuity | | |
| IOP | | |
| Refraction | | |

## REASON FOR REFERRAL

| | | | | |
|---|---|---|---|---|
| ☐ Cataract (@ hospital) | ☐ ARMD (wet/dry) | ☐ Vitreous hemorrhage | ☐ Cornea | ☐ Papilledema / Neuro |
| ☐ Cataract (private centre) | ☐ CRVO / BRVO | ☐ ERM / Mac hole / VMT | ☐ Pterygia | ☐ Uveitis |
| ☐ Glaucoma / IOP | ☐ Diabetic Retinopathy | ☐ Choroidal Nevus | ☐ Keratoconus | ☐ Plaquenil |
| ☐ YAG LPI /Narrow Angles | ☐ DME / CME | ☐ CSR | ☐ Cornea Transplant | ☐ Chalazion |
| ☐ YAG Capsulotomy | ☐ Retinal Tear / Hole / RD | ☐ ROP | ☐ Refractive Laser | ☐ Other: _____ |

## NOTES / MEDICATIONS

Special needs:

☐ Mobility

☐ Cognitive

☐ Deaf/Mute

☐ Other: _____