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
- Cornea
- Cataract
- Complex Ant Seg

☐ Dr. Shaobo Lei
- Medical Retina
- Surgical Retina
- Neuro

☐ 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 / RLE	☐ ARMD (wet/dry)	☐ Epiretinal Membrane	☐ Cornea	☐ Papilledema / Neuro
☐ Glaucoma / IOP	☐ CRVO / BRVO	☐ Macular Hole / VMT	☐ Pterygia	☐ Uveitis
☐ YAG/SLT Laser	☐ Diabetic Retinopathy	☐ Choroidal Nevus	☐ Keratoconus	☐ Plaquenil
☐ 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: _____