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

NOTES / MEDICATIONS

Special needs:

☐ Mobility
☐ Cognitive
☐ Deaf/Mute
☐ Other: _____