

- | | | | |
|---|--|--|--|
| ☐ Dr. Aaron Chan
- Cataract
- Medical Retina
- Glaucoma | ☐ Dr. Nour Nofal / Dr. Ore Erikotola
- Cornea
- Cataract
- Complex Ant Seg | ☐ Dr. Eunice You
- Cataract
- Medical Retina
- Uveitis
- Glaucoma | ☐ 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) | ☐ Retinal Tear / Hole | ☐ Cornea | ☐ Papilledema / Neuro |
| ☐ Cataract (private centre) | ☐ CRVO / BRVO | ☐ Retinal Detachment | ☐ Pterygia | ☐ Uveitis |
| ☐ Glaucoma / Elevated IOP | ☐ CRAO / BRAO | ☐ Choroidal Nevus | ☐ Keratoconus | ☐ Chalazion |
| ☐ YAG LPI / Narrow Angles | ☐ Diabetic Retinopathy | ☐ CSR | ☐ Cornea Transplant | ☐ Other: _____ |
| ☐ YAG Capsulotomy | ☐ DME / CME | ☐ Plaquenil Check | ☐ Refractive Laser | |

NOTES + MEDICATIONS

Please list medications

Special needs:

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