Referral Request

Referring Doctor: ______________________
Clinic Name: ______________________
Clinic Address: ______________________
Clinic Phone: ______________ Clinic Fax: ______________

Patient Name: ______________________
DOB: __________ Age: ______ ☐ Male ☐ Female
Address: ______________________
Health Card #: ______________ Version Code: ______
Home Phone: ______________ Mobile: ______________
Email Address: ______________________
Mobility Status: ☐ Wheelchair Is patient able to transfer? ☐ Yes ☐ No

Reason for Referral ☐ Cataract ☐ Laser Vision correction
☐ Other ______________

Patient History:

Medical History ______________________
____
Medications ______________________
Allergies ______________________
Past Ocular History ______________________
☐ Glasses ☐ Contacts

Manifest Refraction	OD	______	OS	______
Auto Refraction	OD	______	OS	______
K's	OD	______	OS	______
IOP	OD	______	OS	______
UCVA	OD	______	OS	______
BCVA	OD	______	OS	______

Slit Lamp

Comments

Please fax back to Clearview Institute at 416-289-2318 after each visit. Thank you.