EYE SPECIALISTS
OF NORTHERN ONTARIO

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Affix pt label

NON-OPTOMETRIST/ NON-OPHTHALMOLOGIST REFERRAL

Disclaimer: For emergencies (24-72H) please do not rely on fax for an appointment.

Please call the office and we will do our best to accommodate your request. Alternatively, send patient to ER.

Main reason for referral: _____ **Pt AGE:** _____

_____

Patient's optometrist: _____

Diabetic? ☐ yes ☐ no

RIGHT EYE	**LEFT EYE**	**Current gtts**
Corrected VA: _____	**Corrected VA:** _____	_____
IOP: _____	**IOP:** _____	_____
		_____
Cornea: ☐ clear ☐ not clear	Cornea: ☐ clear ☐ not clear	_____
Red Reflex? ☐ yes ☐ no	Red Reflex? ☐ yes ☐ no	
Hx of cataract surgery? ☐ yes ☐ no	Hx of cataract surgery? ☐ yes ☐ no	
Hx of injections into eye? ☐ yes ☐ no	Hx of injections into eye? ☐ yes ☐ no	

Other:

NAME OF PHYSICIAN:
DATE: