EYE SPECIALISTS
OF NORTHERN ONTARIO

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Affix Pt info/label here

REFERRAL FROM OPTOMETRY

Disclaimer: ***For emergencies (within 1 week) please do not rely on fax for an appointment****. Call our office directly and we will do our best to accommodate your request. Alternatively, you can send patient to ER.*

DATE:

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

_____

Has this patient seen an ophthalmologist in the past year? ☐ NO ☐ YES
(Dr._____)

Please complete below from your last exam:

RIGHT EYE

BCVA: _____
IOP: _____

Anterior:

Lens: ☐ phakic ☐ pseudophakic

Cornea: ☐ clear ☐ not clear

AC: ☐ quiet ☐ cells

Posterior:

☐ mac edema/blood
☐ diabetic retinopathy
☐ retinal tear/detachment/PVD
☐ disc cupped

Other:

LEFT EYE

BCVA: _____
IOP: _____

Anterior:

Lens: ☐ phakic ☐ pseudophakic

Cornea: ☐ clear ☐ not clear

AC: ☐ quiet ☐ cells

Posterior:

☐ mac edema/blood
☐ diabetic retinopathy
☐ retinal tear/detachment/PVD
☐ disc cupped

Other:

Current gtts

_____
_____
_____
_____

_____
Optom name (print)