WATERLOO WELLINGTON Regional Coordination Centre

Regional Coordination Centre Local **Fax Number: 519-621-0059**
Toll-Free **Fax Number: 1-833-583-2484**
Local Phone Number: **519-947-1000 option 5**
Toll-Free Phone Number: 1-844-204-9088

Waterloo Wellington Cataract Central Intake Referral Form

Please Note: This form is intended for **non-urgent Cataract referral requests**. For **urgent referrals, please follow standard procedures or contact the hospital 'on call' ophthalmologist for direction**. All patients referred for cataract surgery should have an optometry evaluation.

*** Indicates a required field**

Referral Date (mm/dd/yyyy)*:_____

Patient Surname*: _____

Patient First Name*: _____

DOB*: _____ OHIP#*:_____

Address*:_____

Telephone* (res):_____ (bus):_ _____ (cell):_____

City*:_____ Prov/State*:_____ Postal/Zip*:_____

Referral Information

Centralized referral for cataract surgery is designed to help **reduce wait times** by providing **patients with choices**. **Please discuss with your patient the current wait time for cataract surgery in your region**. You can see current wait times for cataract surgery by surgeon name using the search term "cataract" on the Ocean Healthmap (https://oceanhealthmap.ca/). Patients have a right to choose their preferred option of shortest wait time, specific region/practice, or specific surgeon.

Patient preference for cataract surgeon*:

☐ Shortest Wait Time

Patient willing to travel to neighbouring cities for surgery: ☐ Yes ☐ No

If yes, Patient is willing to consider cataract surgery in (select as many as applicable):

☐ Cambridge ☐ Kitchener-Waterloo ☐ Guelph

☐ Closest to Home

Specific surgeon practice/location that is most convenient to your patient:

☐ Yes ☐ No

If yes, specify: _____

☐ Specific Surgeon

Select Surgeon (please pick one):

☐ Dr. Alangh	☐ Dr. Chan	☐ Dr. Desai	☐ Dr. Jellie	☐ Dr. McAlister
☐ Dr.McCuaig	☐ Dr. Neufeld	☐ Dr. Peng	☐ Dr. Rayat	☐ Dr. Rodriguez
☐ Dr. Weinstein	☐ Dr. Wilkinson	☐ Dr. Xu	☐ Dr. Yepes	☐ Dr. Zafar

Comments:

WATERLOO REGIONAL EYE PROGRAM

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Will the patient require a special feature implant? ☐ Yes ☐ No

If yes, select all that apply*: ☐ Toric ☐ Multifocal ☐ Unsure

Reason for Referral*:

Patient Health History

Current Spectacles

Right Eye : _____ VA:20/_____

Left Eye: _____ VA:20/_____

Does the patient wear prism(s) in his/her current spectacles? ☐ Yes ☐ No

If yes: Right Eye (Prism):_____
Left Eye (Prism):_____

Current or last IOP

Right Eye (mmHg) :_____
Left Eye (mmHg):_____

Current Eye Drops: _____

Does Patient wear contact lenses? ☐ Yes ☐ No

If Yes, indicate: ☐ Soft ☐ Rigid Gas Permeable ☐ Other:_____

Surgical History

Has the patient had previous corneal refractive surgery? ☐ Yes ☐ No

If Yes, indicate:

Type of surgery*: ☐ LASIK ☐ PRK ☐ RK ☐ Unsure/Unknown ☐ Other

If LASIK or PRK please indicate: ☐ Myopia ☐ Hyperopia

If Other, specify: _____

Name of Surgeon:_____Location:_____

Approximate Date of Surgery (i.e. year): _____

Please list Pre-Op refraction and K's (if known):

Right Eye: VA:20/: _____ K's(um/d):_____ Refraction: _____

Left Eye: VA:20/: _____ K's(um/d):_____ Refraction: _____

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Has the patient had previous eye surgery or laser treatment? ☐ Yes ☐ No

If yes, please provide details related to all eye surgeries:

Left Eye Details:

Type(s) of Surgery:

Name(s) of Surgeon:

Location(s):

Approximate date(s) of Surgery (i.e. year):

Notes:

Right Eye Details:

Type(s) of Surgery:

Name(s) of Surgeon:

Location(s):

Approximate date(s) of Surgery (i.e. year):

Notes:

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Additional Relevant Information:

Please provide any additional relevant information on patient's past **ocular history**

Please provide any additional relevant information on patient's past **systemic history**:

Supporting Documentation:

Please attach any relevant files:

- Referral Notes
- Consultation Reports
- Images
- Visual Fields

Referring Provider Information*

Name: _____

Address: _____

Phone: _____

Fax:_____

Billing Number: _____

Date:_____

Signature: _____

FOR INTERNAL USE ONLY

Ophthalmologist:

FOR MEDICAL SPECIALIST OFFICE STAFF USE ONLY

Ophthalmologist Consultation Date:

☐ Non-Surgical Candidate

☐ Incomplete Referral

Reason: