

**** This form is for non-urgent cataract referrals only. For urgent referrals, follow standard procedures or contact 'on call' ophthalmologist ****

Last Name:	First Name:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X _____
DOB (DD/MM/YY):	Phone (Primary):	Phone (Other):
Address:	City:	Postal Code:
Health Card #:	Social Barriers:	Language Barrier: <input type="checkbox"/> YES <input type="checkbox"/> NO
Height:	Weight:	Identifies as First Nations, Inuit, Metis
		Language Spoken:
		Allergies: <input type="checkbox"/> NKA

MANDATORY* Information Section:

Patient Preference: <i>Please Check One</i>	<input type="checkbox"/> Shortest Wait	<input type="checkbox"/> Closest to Home	<input type="checkbox"/> Specific Surgeon:
	<input type="checkbox"/> Other Preference:	<input type="checkbox"/> Patient willing to travel to neighbouring cities (Guelph, Cambridge, Kitchener)	
Reason for Referral: <i>Select or Indicate</i>	<input type="checkbox"/> Routine Cataract	<input type="checkbox"/> Both Eyes (OU)	<input type="checkbox"/> Left Eye (OS) <input type="checkbox"/> Right Eye (OD)
	<input type="checkbox"/> Specialty IOL Implant	<input type="checkbox"/> Toric	<input type="checkbox"/> Multifocal <input type="checkbox"/> Unsure
	<input type="checkbox"/> Previous Corneal Refractive Surgery		

OPTIONAL Information Section – Please attach optometry report OR complete information below:

<input type="checkbox"/> Optometrist Report Attached	<input type="checkbox"/> Other Clinical Documentation Attached (Ocular History, Systemic History, Referral Notes, Consultation Reports, Images, Visual Fields)
Current Spectacles: <input type="checkbox"/> Right Eye: <input type="checkbox"/> VA:20/ <input type="checkbox"/> Left Eye: <input type="checkbox"/> VA:20/ <input type="checkbox"/> Patient wears prism(s) in current spectacles If so: <input type="checkbox"/> Right prism: <input type="checkbox"/> Left prism: Current Eye Drops:	Current or Last IOP: <input type="checkbox"/> Right Eye (mmHg): <input type="checkbox"/> Left Eye (mmHg): Current Contact Lenses: <input type="checkbox"/> Patient wears contact lenses: <input type="checkbox"/> Soft <input type="checkbox"/> Rigid Gas Permeable <input type="checkbox"/> Other:
Corneal Refractive Surgical History: <input type="checkbox"/> No previous eye surgery Type: <input type="checkbox"/> LASIK <input type="checkbox"/> PRK <input type="checkbox"/> RK <input type="checkbox"/> Unsure <input type="checkbox"/> Other: If LASIK or PRK: <input type="checkbox"/> Myopia <input type="checkbox"/> Hyperopia Name of Surgeon: <input type="checkbox"/> Approx Date (Year): List Pre-Op Refraction and Ks (if known): <input type="checkbox"/> Right Eye: VA:20/ Ks: Refraction: <input type="checkbox"/> Left Eye: VA:20/ Ks: Refraction:	General Eye Surgical History: <input type="checkbox"/> Patient has had previous eye surgery or laser treatment <input type="checkbox"/> Right Eye Surgery Type: Name of Surgeon: <input type="checkbox"/> Approx Date (Year): Other Notes: <input type="checkbox"/> Left Eye Surgery Type: Name of Surgeon: <input type="checkbox"/> Approx Date (Year): Other Notes:

Referring Provider Information*: Name: Address: Phone: <input type="checkbox"/> Fax: OHIP Billing Number:	FOR INTERNAL USE ONLY Ophthalmologist:
	FOR MEDICAL SPECIALIST OFFICE STAFF USE ONLY Ophthalmologist Consultation Date:
Signature: <input type="checkbox"/> Date:	