WATERLOO WELLINGTON Regional Coordination Centre

Waterloo Wellington Cataract Central Intake Referral Form
Regional Coordination Centre Local Fax Number: 519-621-0059
Toll-Free Fax Number: 1-833-583-2484
Telephone Number: 519-947-1000

Last Name:	First Name:	Gender: ☐ Male ☐ Female ☐ X _____
DOB:	Phone (Primary):	Phone (Other):
Address:	City:	Postal Code:
Health Card #:	☐ Social Barriers:	Language Barrier: ☐ YES ☐ NO
Height: Weight:	☐ Aboriginal Status	Language Spoken:
Primary Care Provider:		Allergies: ☐ NKA

Schedule Patient for:	☐ Shortest Wait	☐ Preferred City:	☐ Preferred Surgeon:
Referral Request:	☐ Special Feature Implant Required	Type (check all that apply): ☐ Toric ☐ Multifocal ☐ Unsure	
Reason for Referral: ***Note: This form is for non-urgent Cataract referrals only. For urgent referrals, follow standard procedures/contact 'on call' ophthalmologist***			
Other Clinical Documentation (Ocular History, Systemic History, Referral Notes, Consultation Reports, Images, Visual Fields): ☐ Attached			
Primary Problem/Area:		☐ **Required Optometrist Report Attached**	
☐ Right Eye (OD)	☐ Left Eye (OS)	☐ Both Eyes (OU)	☐ Other:

Current Spectacles:
☐ Right Eye: ☐ VA:20/
☐ Left Eye: ☐ VA: 20/
☐ Patient wears prism(s) in current spectacles. If so: ☐ Right prism:
☐ Left prism:

Current or Last IOP:
☐ Right Eye (mmHg):
☐ Left Eye (mmHg):

Current Eye Drops:

Current Contact Lenses:
☐ Patient wears contact lenses:
☐ Soft ☐ Rigid Gas Permeable ☐ Other:

Corneal Refractive Surgical History:
☐ Patient has had previous corneal refractive surgery
Type: ☐ LASIK ☐ PRK ☐ RK ☐ Unsure ☐ Other:
If LASIK or PRK: ☐ Myopia ☐ Hyperopia

Name of Surgeon: Approx Date (Year):
Location:

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:

General Eye Surgical History:
☐ Patient has had previous eye surgery or laser treatment

☐ Right Eye Surgery Type:
Name of Surgeon: Approx Date (Year):
Location:
Other Notes:

☐ Left Eye Surgery Type:
Name of Surgeon: Approx Date (Year):
Location:
Other Notes:

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: