Regional Coordination Centre
CATARACT CENTRAL INTAKE

West Region 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, option 5; Email: cataracts@regionalci.org

** Central Intake will only accept non-urgent referrals for Cataract Surgery **

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

MANDATORY* Information Section:

Patient Preference:	☐ Shortest Wait	☐ Closest to Home	☐Specific Surgeon:	
	☐ Patient willing to travel to neighbouring cities If yes, specify location(s):			
Reason for Referral: ***Select or Indicate***	☐ Routine Cataract	☐ Both Eyes (OU)	☐Left Eye (OS)	☐Right Eye (OD)
	☐ Specialty IOL Implant	☐ Toric	☐Multifocal	☐Unsure
	☐ Previous Corneal Refractive Surgery			

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

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

Referring Provider Information*: Name: Address: Phone: Fax: OHIP Billing Number:	**FOR INTERNAL USE ONLY** Ophthalmologist: **FOR MEDICAL SPECIALIST OFFICE STAFF USE ONLY** Ophthalmologist Consultation Date:
Signature: Date:	Save Referral Print Referral Clear Form

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