LASER OTTAWA VISION EXPERTS

CATARACT/REFRACTIVE LENS EXCHANGE REFERRAL FORM

750 Palladium Dr. Suite 320, Kanata ON K2V 1C7
P 613-509-1313 | **F** 613-663-2971 | 1-844-319-5683 (LOVE)
info@eyeloveclinic.com | eyeloveclinic.com

REFERRING DOCTOR INFORMATION

Doctor Name _____ Billing #_____

Phone _____ Fax_____

Address _____

◯ First Available

PATIENT INFORMATION

Last Name _____ First Name_____

D.O.B. _____ OHIP #_____ VC_____

Home Phone _____ Email_____

Address _____

Currently Driving? ◯ Y ◯ N CTL User? ◯ Y ◯ N Monovision: ◯ Y ◯ N

PATIENT EVALUATION

Unaided Acuity OD 20 /_____ IOP OD_____ mmHg

OS 20 /_____ IOP OS _____ mmHg

Refraction OD _____ BCVA 20 /_____

OS _____ BCVA 20 /_____

Previous Eye History (eye disease, conditions, surgery, trauma): ◯ None, or specify:

_____

Anterior Segment: ◯ Normal

Findings: _____

_____

Posterior Segment: ◯ Normal

Findings: _____

_____

General Health: ◯ Good ◯ IDDM ◯ NIDDM ◯ COPD ◯ HBP

◯ Other:_____

Allergies_____ ◯ NKDA

Signature _____ Date_____