GREAT LAKES EYE CENTRE

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Brantford, ON
N3S 6T6

Tel: 519-752-3200
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CONSULTATION REQUEST FORM

Please fax all referrals to 519-752-3277

To avoid delays in processing your referral, please carefully complete ALL fields. Mandatory fields are marked with (*)
Any accompanying OCT or retinal images can be emailed to: **appointments@drcalotti.com**

DOCTOR INFORMATION:

Referring Doctor*: _____

OHIP Billing #*: _____

Address*:_____ City*: _____

Office Phone #*: _____ Fax* _____

PATIENT INFORMATION:

Last Name*: _____ First Name*: _____

Health Card*: _____ Version Code*: _____ DOB*: _____

☐ Male ☐ Female Address*: _____

City*: _____ Postal Code*: _____

Phone*: _____ E-mail Address* _____

Thank you for your referral. All referrals will be reviewed within 1 week. If you have not been notified of a consultation appointment by that time, please contact our office. For all URGENT referrals, please call our office to confirm we have received your referral.

URGENCY:
☐ **Routine**: next available
☐ **ASAP**: within 1-2 weeks
☐ **Urgent**: within 24 hours (call to confirm)

Reason for referral (please check where applicable)

CATARACT:	☐ Ready for surgery ☐ Patient undecided ☐ Posterior capsular opacification (PCO)	☐ Astigmatism correction candidate ☐ Presbyopia correction candidate		
ANTERIOR SEGMENT:	☐ Pterygium/conjunctiva	☐ Keratitis/Cornea	☐ Iritis	
GLAUCOMA:	☐ Narrow angles Grade: _____	☐ High IOP OD: _____ OS: _____	☐ Disc Cupping : OD: ____ OS: ____	☐ Field Loss: _____
RETINA:	Diabetes: ☐ NPDR ☐ CSME ☐ PDR	ARMD: ☐ Dry ☐ Wet	☐ Retinal Tear/ Hole: _____	☐ Plaquenil check	☐ Macula check (please specify): _____
NEURO:	☐ Optic Nerve Disorder: _____	☐ Field loss: _____	Other: _____		
DRY EYE:	☐ Full Dry Eye Assessment	☐ Miboflo candidate	☐ IPL candidate	☐ Meibomian gland probing candidate	
LID LESION:	☐ Chalazion	Other (please specify): _____			
COSMETIC:	☐ Skin Tag	☐ Dermatochalasis/Blepharoplasty	Other: _____		
ADDITIONAL INFO/ NOTES (*Please include past ophthalmic history)	_____ _____ _____ _____ _____ _____				

Please mark where applicable if your patient may require any accommodations, so we can best meet their needs:
☐ Mobility/Wheelchair bound
☐ Hearing loss
☐ Cognitive impairment
☐ Other: _____

EXAM FINDINGS*	OD	OS
BCVA*:		
REFRACTION*:		
IOP*:		