GREAT LAKES EYE CENTRE

Suite 116-99 Wayne Gretzky Pkwy
Brantford, Ontario
N3S 6T6

Tel: 519-752-3200
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BRANTFORD CLINIC CONSULTATION REQUEST FORM

Please fax your referrals to our central intake fax at 519-752-3277

DOCTOR INFORMATION:

Referring Doctor: _____

OHIP Billing #: _____

Office Phone: _____Fax: _____

PATIENT INFORMATION:

Patient Last Name: _____

First Name: _____

Health Card #: _____Version Code: _____

DOB (Y-M-D): _____ [ ] Male [ ] Female

Address: _____

Phone: _____Alternate Contact: _____

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 directly.

URGENCY:
[ ]Routine
[ ] ASAP
[ ] Urgent (call to confirm)
Special request: _____
_____

Reason for referral (please check/circle where applicable)				
CATARACT:	[ ] Ready for surgery [ ] Patient undecided [ ] Astigmatism correction candidate [ ] Presbyopia treatment candidate			
ANT SEGMENT:	Pterygium/Conjunctiva	Dry Eye	Keratitis/Cornea	Iritis
GLAUCOMA:	Narrow Angles	High IOP	Disc Cupping: OD: ____ OS: ____	Field Loss
RETINA:	Diabetes	ARMD (dry/wet)	Retinal Breaks	Macula Check
NEURO:	Diplopia	Optic Nerve Disorder	Field Loss	
OTHER:				
Eye Exam:	OD	OS		
BCVA:			Remarks/Drawing:	
Refraction:				
IOP:				

Additional Information: _____
_____
_____
_____