PATIENT REFERRAL FORM

From O.D: Dr.

Address:

Phone: Fax:

To M.D: Dr.

Regarding Patient: DOB:

OHIP#: EXP Phone:

Address:

Appointment Date: Eye Examination Date:

Family Physician: Dr.

Reason for referral:

Chief complaint:

History:

Medications:

Allergies:

	Right Eye	*Left Eye*
BCVA		
IOP@		
Refraction		
Anterior Segment		
Fundus		

Additional Test:

Thank you in advance for seeing this patient. I look forward to sharing your impressions.

Sincerely,

O.D: Dr.