

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:

	<i>Right Eye</i>	<i>Left Eye</i>
<i>BCVA</i>		
<i>IOP@</i>		
<i>Refraction</i>		
<i>Anterior Segment</i>		
<i>Fundus</i>		

Additional Test:

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

Sincerely,

O.D: Dr.