PATIENT REFERRAL FORM

O.D:

Address:

Phone: Fax:

To: Dr. Regarding Patient:

OHIP#: EXP

Appointment Date: Date of birth:

Address:

Family Physician:

Phone:

Date of examination:

Reason for referral: _____

Chief complaint: _____

History: _____

Medications: _____

Allergies: _____

Ocular Findings	**Right Eye**	**Left Eye**
BCVA		
Refraction		
IOP@ AM/PM		
Anterior Segment		
Fundus		

Additional Tests: _____

_____

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

O.D: