LASER VISION
LONDON

CATARACT/REFRACTIVE LENS EXCHANGE REFERRAL FORM

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☐ Dr. Rogelstad ☐ Dr. Bursztyn ☐ Dr. Iordanous ☐ Dr. Tingey ☐ Dr. Tong ☐ First Available

REFERRING DOCTOR INFORMATION

Doctor Name _____ Billing #_____

Phone _____ Fax_____

Address _____

PATIENT INFORMATION

Last Name _____ First Name_____

D.O.B. _____ OHIP #_____ VC_____

Home Phone _____ Email_____

Address _____

Currently Driving? ○ Y ○ N CTL User? ○ Y ○ N Monovision: ○ Y ○ N

Mobility Status: ☐ Walking ☐ Walker/Device ☐ Wheelchair-can patient transfer: ○ Y ○ N

PATIENT EVALUATION

Unaided Acuity OD 20 /_____ IOP OD_____ mmHg

OS 20 /_____ IOP OS_____ mmHg

Refraction OD _____ BCVA 20 /_____

OS _____ BCVA 20 /_____

Previous Eye History (eye disease, conditions, surgery, trauma): ○ None, or specify:

_____

Anterior Segment: ○ Normal

Findings: _____

_____

Posterior Segment: ○ Normal

Findings: _____

_____

General Health: ○ Good ○ IDDM ○ NIDDM ○ COPD ○ HTN

○ Other:_____

Allergies_____ ○ NKDA

Signature _____ Date_____