LASER VISION
LONDON

CATARACT/REFRACTIVE LENS EXCHANGE REFERRAL FORM

1695 Wonderland Road North London ON
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SURGEON PREFERENCE

Dr. Bruce Nicols   Dr. Bo Li   Dr.Tayfour   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

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   HBP

Other:____

Allergies____   NKDA

Signature ______________________ Date______________________