

REFERRING TO: _____ **Date:** _____

Specify: Dr : _____

No Preference for Doctor / Please assign according to availability

PATIENT DETAILS: _____ **RAMQ #:** _____

First Name: _____ Tel. #1: _____

Last Name: _____ Tel. #2: _____

Address: _____ Date of birth: _____

Gender: M F

PREFERRED CLINIC: _____

<input type="checkbox"/> 8000 Decarie blvd., suite 440 Montreal, Quebec H4P 2S4 Tel.: 514-340-3937 Fax: 514-340-2729 cogestiondecarie@oeilsantemd.com	<input type="checkbox"/> 625 Président-Kennedy ave., suite 1503 Montreal, Quebec H3A 1K2 Tel. :514-849-9215 Fax: 514-849-5115 cogestionpresidentkennedy@oeilsantemd.com	<input type="checkbox"/> Mega Centre des Sources 2415A Transcanadienne rd, Pointe-Claire, Quebec H9R 5Z5 Tel.: 514-340-3937 Fax: 514-669-6422 cogestionpointeclaire@oeilsantemd.com
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REFERRAL REASON: _____

Please complete all relevant details and **email** or fax the form to the appropriate clinic. Emails are preferred.

General **Cataract** **Retina** **Glaucoma** **Cornea** **Oculoplastics** **Pediatrics** **Other**

Loss of vision OD OS OU Gradual Sudden Transient Constant Curtain

How long and since when? __ Days __ Weeks __ Months __ Years

<input type="checkbox"/> Pain	<input type="checkbox"/> Diplopia	<input type="checkbox"/> Itching and burning
<input type="checkbox"/> Flashes of light	<input type="checkbox"/> Photophobia	<input type="checkbox"/> Redness
<input type="checkbox"/> New floater(s)	<input type="checkbox"/> Tearing	<input type="checkbox"/> Swollen lids
<input type="checkbox"/> Metamorphopsia / Distortion	<input type="checkbox"/> Foreign body sensation	<input type="checkbox"/> Discharge

OD	Visual Acuity 20/	IOP	OS	Visual Acuity 20/	IOP
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Clinical information: _____

Previous ocular surgery / disease:	Clinic use only	<input type="checkbox"/> Refused
	Date of receipt:	
	Triage performed by:	

Please attach any relevant examination results to this consultation request.

REFERRED BY: _____

Last Name (block letters): _____ First Name (block letters): _____

License #: _____ Fax #: _____

Signature: _____