œil santé
eye health md

8000, boul. Décarie, Suite 440, Montréal, QC H4P 2S4 www.EyeHealthMD.com
514-340-EYES (3937) Fax: 514-340-2729 info@EyeHealthMD.com

Date : **Delay** : ________ days / weeks / months

CONSULTATION REQUEST

Now accepting a greater volume of new patients

REFERRING TO

○ **No Preference** for Doctor/Please assign according to availability

Dr: ___________________________

PATIENT DETAILS

RAMQ # ____

First Name : ______________________________________

Tel 1 # ____________________ Tel 2 # ____________________

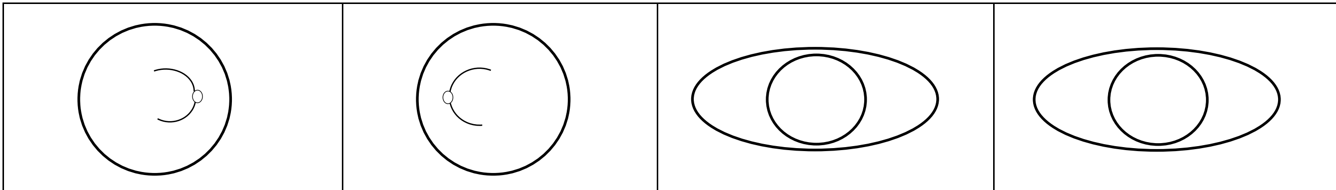
Last Name : ______________________________________

Address : ____

DOB : _____________________ □ M □ F

____

REFERRAL REASON			❑ **Cataract** ❑ **Retina** ❑ **Glaucoma** ❑ **Cornea** ❑ **Other**		
Eye Affected: **OD** **OS** **OU** Is Vision Affected? □ Yes □ No			Onset: □ Sudden □ Gradual Duration: _______ Days/ Weeks/ Months/ Years		
OD	**UCVA** 20/	**IOP**	**OS**	**UCVA** 20/	**IOP**
MR			MR		



REFERRED BY

Office Coordinates :

Office **fax** :

First Name : ______________________________

Last Name : ______________________________

Signature : ______________________________
License

Clinic use only:
Date Received:
By:
V 10.0

Please complete any or all relevant details on the form or you may fax/email us your usual referral form.
Urgent appointments should be managed by phone.
Dial “3” for medical professionals.

Please include your office’s **fax #** to send our reply note