2211 Carling Avenue
Ottawa, ON K2B 7E9

REFERRAL FORM

[ ] Dr. R. Tuli **[ ] Dr. T. Lee** **[ ] Dr. W. Britton** **[ ] Dr. A. McLaughlin**

PATIENT INFORMATION

Name:	**DOB:**	**Address:**
HCN:	**Phone #:**	**Private Insurance: [ ] Yes [ ] No**

REFERRAL REQUEST **[ ] OD [ ] OS**

[ ] Retinal Detachment	[ ] Trauma	[ ] Diabetic Retinopathy	[ ] VH
[ ] Retinal Tear __o'clock	[ ] Wet AMD/CNV	[ ] CSR	[ ] PVD
[ ] Retinal Hole	[ ] Macular Edema	[ ] Macular Hole	[ ] Irivne Gas
[ ] Choroidal Melanoma	[ ] RVO	[ ] ERM/VMT	[ ] NVG

[ ] Other/Notes: _____

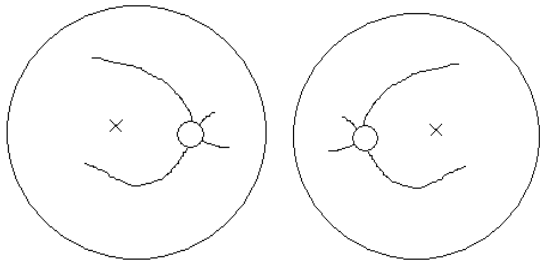
_____

BCVA: OD_____ OS_____ **IOP**: OD _____ OS _____

Ocular History: _____ **Medical History**: _____

_____ _____

Comments:



Referring Doctor

Name:	**Billing #:**
Office Phone #:	**Office Fax #:**

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