CONTACT LENS REFERRAL FORM

Fax to: 519-968-3695

PATIENT

Name (first)_____(last)_____ DOB (m)_____(d)_____(y)_____

Phone _____ Address_____

City_____ Province _____ Postal Code_____

EYE EXAM Date of Exam _____

OD:	ADD:	△	BCVA:
OS:	ADD:	△	BCVA:

Previous CL wear? Y / N

Retinal condition affecting BCVA? OD____ OS____ Please specify _____

Cataract affecting BCVA? OD____ OS____

Remarks _____

REASON FOR REFERRAL

Medical:
___Keratoconus
___Corneal Degeneration
___Needs BCL
___Corneal Ectasia
___Refractive Surgery Complication (RK, Lasik)
___Recurrent Corneal Erosion
___Dry Eye
___Corneal Scar / Opacity / Irregularity
___Other: _____

Refractive:
___Presbyopia
___Astigmatism
___Myopia / Hyperopia
___Anisometropia
___Subjective Visual Abberation
___Inadequate vision with glasses
___Inadequate vision with current CL
___Inadequate comfort with current CL
___Other: _____

REFERRED BY

Practice Name _____

Practitioner Name _____MD / OD / RO

Fax Number_____

*Thank you for your kind referral. You will receive a full report after the patient has been seen at our office. As we don't offer primary eye care or optical services, all patients will be instructed to return to the referring provider for annual eye exams, spectacle therapy and vision therapy. Please call us with any question: 519-997-2361