

Routine Urgent

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Dr. Sareya Khatkur Dr. Aziza Patel Any Doctor

PATIENT INFORMATION

NAME			
DOB		GENDER	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X
OHIP			
ADDRESS			
PHONE		EMAIL	

REFERRING DOCTOR

NAME		CLINIC NAME	
ADDRESS			
PHONE		FAX	
EMAIL			

REASONS / CONDITIONS FOR REFERRAL

<ul style="list-style-type: none"> <input type="checkbox"/> Blepharospasm (Eyelid Twitch) <input type="checkbox"/> Diabetic Work-Up <input type="checkbox"/> Hydroxychloroquine/Plaquenil Work-Up <input type="checkbox"/> Cataracts <input type="checkbox"/> Allergic Conjunctivitis <input type="checkbox"/> Keratoconus <input type="checkbox"/> Trauma <input type="checkbox"/> Infection (Eyelids or Eyes) <input type="checkbox"/> Foreign Body Removal <input type="checkbox"/> Contact Dermatitis (Eyelids) <input type="checkbox"/> Glaucoma Work-Up <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Spectacle Correction Needed (Hyperopia, Myopia, Presbyopia, Astigmatism) <input type="checkbox"/> Strabismus (EyeTurn) <input type="checkbox"/> Amblyopia (Lazy Eye) <input type="checkbox"/> Family History of Eye Disease (If so, which one(s)) _____ <input type="checkbox"/> Other: _____ 	<ul style="list-style-type: none"> <input type="checkbox"/> DRY EYE WORK-UP <i>Please check which applies:</i> <input type="checkbox"/> General Dry Eye Disease Work-Up <input type="checkbox"/> Keratoconjunctivitis Sicca <input type="checkbox"/> Sjogren's Syndrome <input type="checkbox"/> Ocular Rosacea <input type="checkbox"/> Blepharitis <input type="checkbox"/> Meibomian Gland Dysfunction <input type="checkbox"/> Thyroid Related Dry Eye Disease (Graves Disease, Etc) <input type="checkbox"/> Other: _____ Treatment recommended (if any) <input type="checkbox"/> As per our recommendation based on results of our dry eye work-up <input type="checkbox"/> Intense Pulsed Light (IPL) <input type="checkbox"/> Radio Frequency (RF) <input type="checkbox"/> Punctal Plugs <input type="checkbox"/> Therapeutics (Drops, Ointments, Etc) <input type="checkbox"/> Meibomian Gland Expression
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