

# CONSULT REQUEST FORM

## Patient & Appointment Information

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

DOB DD/MM/YY  Male  Female Weight \_\_\_\_\_ [lbs /kg]

AHC# \_\_\_\_\_ WCB# / Accident Date \_\_\_\_\_ DD/MM/YY

Appt. Date \_\_\_\_\_ Time \_\_\_\_\_

## Physician PRAC ID:

Referring Physician \_\_\_\_\_

Clinic \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Copy to Dr. \_\_\_\_\_

Fax Copy to Dr. \_\_\_\_\_

Signature \_\_\_\_\_

## REASON FOR REFERRAL

- Headaches
- Foreign Body
- Floater
- Eye Strain
- Red Eye
- Flashes
- Blurred Vision
- Trauma
- Diabetes
- Eyelid
- Hypertension
- Dry Eye

Medication (s)

\_\_\_\_\_

\_\_\_\_\_

Other

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

