iCare
Surgical & Optical Centre

2148 Carling Ave
Suite #205
Ottawa, Ontario
K2A 1H1

Phone: 613.596.0300
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Name of Patient:	
OHIP:	
DOB:	
Phone:	
Date:	

MANDATORY CODIFICATION ☐ Semi Urgent (1 to 3 weeks) ☐ Priority (1 to 4 months) ☐ Elective (4+ months)

REASON FOR REFERRAL

RETINA	LASERS	GENERAL	OTHER
☐ Dry AMD	☐ Glaucoma (SLT)	☐ Cataract	☐ _____
☐ Wet AMD	☐ Narrow Angle (LPI)	☐ Refractive Cataract Sx	
☐ Diabetes	☐ PCO (Yag Cap)	☐ Glaucoma	
☐ Vein Occlusion	☐ Retina Hole/Tear	☐ Dry Eye	
☐ ERM/VMT	☐ PRP (Diabetic)	☐ Pterygium	
☐ CSR			

BCVA		
	OD	
	OS	

IOP		
	OD	
	OS	

Ophthalmologist / Optometrist: _____

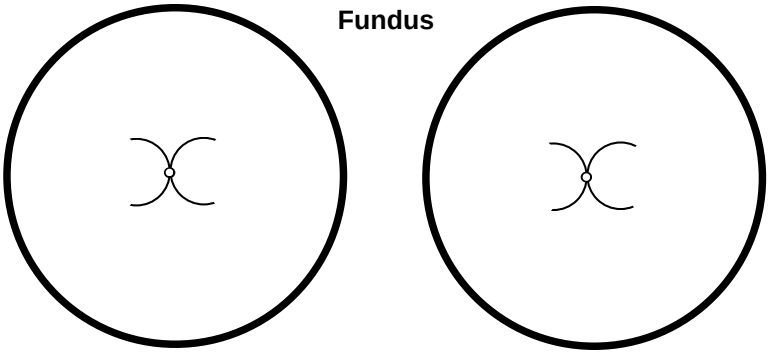
Billing #: _____

Referral Office Name & Address: _____

_____

OD	OS	NOTES:

Fundus



RESERVED FOR DOCTOR				
CODE	TESTS			
A (1 to 3 weeks)	Angiography	VF 24-2	Biometry	Corneal Topography
B (1 to 4 months)	RET OCT	VF 10-2	Pachymetry	Anterior segment OCT
C (4+ months)	GL OCT	VF Estermann	Fundus Photography	Ultrasound