iCare Medical Centre

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icarecentre.org
general@icarecentre.org

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

MANDATORY CODIFICATION	▢ Semi-Urgent (1 - 3 weeks)	▢ Priority (1 - 4 Months)	▢ Elective (4 + Months)

REASON FOR REFERRAL	

RETINA	LASERS	GENERAL	OTHER
▢ Dry AMD ▢ Wet AMD ▢ Diabetes ▢ Vein Occlusion ▢ ERM / VMT ▢ CSR ▢ CNVM	▢ PCO (YAG Cap) ▢ PRP	▢ Cataract ▢ Refractive Cataract Sx	▢ _____

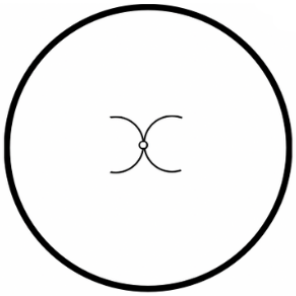
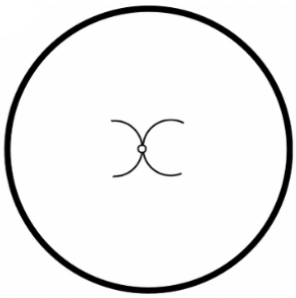
BCVA		IOP	
OD		OD	
OS		OS	

Ophthalmologist / Optometrist:_____

Billing #:_____

Referral Office Name & Address:_____

_____

OD	OS	Notes
		

Reserved For Doctor				
CODE	TESTS			
A (1 - 3 Months)	Angiography	VF 24 - 2	Biometry	Corneal Topography
B (1 - 4 Months)	RET OCT	VF 10 - 2	Pachymetry	Anterior Segment OCT
C (4 + Months)	GL OCT	VF Estermann	Fundus Photography	Ultrasound