iCare Surgical Centre

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K2A 1H1

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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	☐ Glaucoma (SLT) ☐ Narrow Angle (LPI) ☐ PCO (YAG Cap) ☐ Retina Hole/ Tear ☐ PRP (Diabetic)	☐ Cataract ☐ Refractive Cataract Sx ☐ Glaucoma ☐ Dry Eye ☐ Pterygium	☐ _____

BCVA		IOP	
	OD		OD
	OS		OS

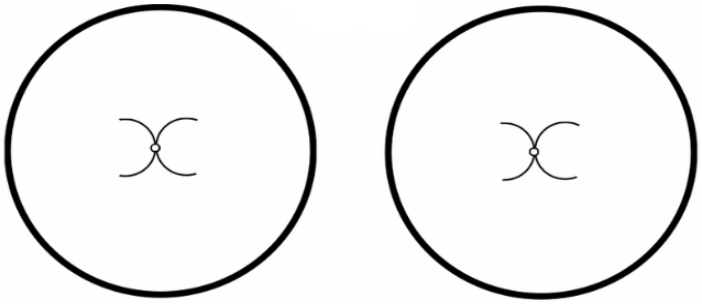
Optometrist:_____

Billing #:_____

Referral Office Name & Address:_____

_____

OD	OS



Notes

Reserved For Doctor				
CODE	TESTS			
A (1 - 3 Weeks)	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