GREAT LAKES
EYE CENTRE

URGENT RETINA REFERRAL REQUEST

Patient Info:
Name: _____
DOB: _____
OHIP #: _____
Address: _____
Phone: _____
E-mail Address: _____

Please call office to confirm for all urgent referrals

- ☐ Wet AMD
- ☐ Proliferative diabetic retinopathy/VH
- ☐ Diabetic macular edema
- ☐ CRVO
- ☐ BRVO
- ☐ Retinal Tear (please specify location)
- ☐ Retinal Detachment
- ☐ CRAO
- ☐ BRAO

- ☐ OD
- ☐ OS

BCVA OD: _____

BCVA OS: _____

Past Ophthalmic History: _____

_____

_____

Referring Optometrist: _____

OHIP Billing Number: _____

*Please attach exam findings to this referral

Thank you!