

Referring Doctor OHIP Billing #

Address City Postal Code

Office Phone # Fax #

Thank you for your referral. All referrals are reviewed within 48 hours. Your office will be notified by fax of patient's appointment. To avoid a delay in honouring your consult request, please carefully complete all fields. If possible, a demographic label is preferred, as verification will be required for incomplete or illegible forms.

Last Name First Name

Health Card # Version Code DOB

Address City Postal Code

Home # Mobile # Email

<p>Please mark 'X' where applicable</p> <p><input type="checkbox"/> First available location or <input type="checkbox"/> First available Consultant</p> <p><input type="checkbox"/> Prism Mississauga</p> <p><input type="checkbox"/> Prism Brampton</p> <p><input type="checkbox"/> Prism King</p>	<p>Please mark 'X' where applicable</p> <p>MEDICAL URGENCY:</p> <p><input type="checkbox"/> Routine: next available</p> <p><input type="checkbox"/> ASAP: within 24 hours</p> <p><input type="checkbox"/> Same Day / Urgent : within 12 hours</p>
Reason for referral [Please mark 'X' where applicable]	
CATARACT	<input type="checkbox"/> Ready for surgery <input type="checkbox"/> Premium options discussed: <input type="checkbox"/> IOL Master biometry preferred <input type="checkbox"/> Patient undecided <input type="checkbox"/> Astigmatism correction candidate <input type="checkbox"/> Presbyopia treatment candidate <input type="checkbox"/> PCO-posterior capsular opacification
ANT SEGMENT	<input type="checkbox"/> Pterygium/Conjunctiva <input type="checkbox"/> Dry eye <input type="checkbox"/> Keratitis/Cornea <input type="checkbox"/> Iritis <input type="checkbox"/> Anterior Uveitis
GLAUCOMA	<input type="checkbox"/> Narrow angles <input type="checkbox"/> High IOP <input type="checkbox"/> Disc cupping <input type="checkbox"/> Field loss
PEDIATRICS	<input type="checkbox"/> Amblyopia <input type="checkbox"/> Strabismus <input type="checkbox"/> Tearing <input type="checkbox"/> MRX
PLASTICS	<input type="checkbox"/> Eyelid <input type="checkbox"/> Tearing <input type="checkbox"/> Orbit <input type="checkbox"/> Cosmetic
RETINA	<input type="checkbox"/> Diabetes <input type="checkbox"/> ARMD (dry/wet) <input type="checkbox"/> Retinal breaks <input type="checkbox"/> Plaquenil check <input type="checkbox"/> Posterior Uveitis
OTHER	
NOTES	

Please check X where applicable if there are any special needs that may require accommodation:

- Mobility
- Range of Motion
- Cognitive
- Hearing loss
- Other

Prism Eye Institute is committed to maintaining an accessible environment for persons with disabilities in the delivery of its goods and services.

Eye Exam	OD	OS
BCVA		
Refraction		
IOP		

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