CONSULTATION REQUEST

www.eyehealthmd.com

REFERRING TO: **Date:**

☐ Specify: Dr :

☐ **No Preference for Doctor** / Please assign according to availability

PATIENT DETAILS: **RAMQ #:**

First Name: Tel. #1:

Last Name: Tel. #2:

Address: Date of birth:

Gender: ☐ M ☐ F

PREFERRED CLINIC:

☐ 8000 Decarie blvd.,
suite 440
Montreal, Quebec
H4P 2S4
Tel.: 514-340-3937
Fax: 514-340-2729
cogestiondecarie@oeilsantemd.com

☐ 625 Président-Kennedy ave.,
suite 1503
Montreal, Quebec
H3A 1K2
Tel. :514-849-9215
Fax: 514-849-5115
cogestionpresidentkennedy@oeilsantemd.com

☐ Mega Centre des Sources
2415A Transcanadienne rd,
Pointe-Claire, Quebec
H9R 5Z5
Tel.: 514-340-3937
Fax: 514-669-6422
cogestionpointeclaire@oeilsantemd.com

REFERRAL REASON:

Please complete all relevant details and **email** or fax the form to the appropriate clinic. Emails are preferred.

☐ **General** ☐ **Cataract** ☐ **Retina** ☐ **Glaucoma** ☐ **Cornea** ☐ **Oculoplastics** ☐ **Pediatrics** ☐ **A-scan** ☐ **Other**

☐ Loss of vision ☐ OD ☐ OS ☐ OU ☐ Gradual ☐ Sudden ☐ Transient ☐ Constant ☐ Curtain
How long and since when? __ Days __ Weeks __Months __Years

☐ Pain
☐ Flashes of light
☐ New floater(s)
☐ Metamorphopsia / Distortion
☐ Diplopia
☐ Photophobia
☐ Tearing
☐ Foreign body sensation
☐ Itching and burning
☐ Redness
☐ Swollen lids
☐ Discharge

OD	**Visual Acuity** 20/	**IOP**	**OS**	**Visual Acuity** 20/	**IOP**

Clinical information:

Previous ocular surgery / disease:

Clinic use only ☐ Refused
Date of receipt:
Triage performed by:

Please attach any relevant examination results to this consultation request.

REFERRED BY:

Last Name (block letters): First Name (block letters):

License #: **Fax #:**

Signature: