Patient Referral Overview

Patient Name: _____ ☐ OHIP Patient

Date of Birth: _____ ☐ RLE Patient

Health Card Number: _____ Exp. Date: _____ ☐ LVC Patient

Phone Number: _____ ☐ BLEPH Patient

Mailing Address: _____

_____

_____

Email: _____

☐ New Patient

☐ Existing FEC Patient

Referring Physician: _____

Billing #: _____

OCULAR PATHOLOGY

☐ Early Lenticular Changes

☐ Advanced Lenticular Changes / Cataract

☐ Visual Acuity Changes

☐ Corneal Pathology: _____

☐ Dry Eye

☐ Laser Vision Enhancement

Date of Initial Procedure: _____

☐ Other (describe): _____

_____

EYE INVOLVED

☐ OD

☐ OS

☐ OU

EYE DOMINANCY

☐ OD

☐ OS

Signature: _____ Print Name: _____

Date: _____ Return form to: **info@focuseye.com**

For internal use only: Focus graduated patient: ☐ Yes ☐ No Date of graduation: _____ Surgeon: _____

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