

BENOË

LASER EYE CENTRE

CONSULTATION REQUEST FORM

All referrals are reviewed within 2-3 business days. A notification of the patient's appointment will be provided via fax. Form can be **Faxed:** 905-785-8384 **OR emailed:** referral@blec.ca

LOCATION: FIRST AVAILABLE MISSISSAUGA OAKVILLE GEORGETOWN

REFERRING DR.		BILLING NUMBER	
ADDRESS		EMAIL	
OFFICE PHONE		OFFICE FAX	

PATIENT DEMOGRAPHICS

PATIENT FIRST NAME		PATIENT LAST NAME	
PATIENT ADDRESS		CITY	
PATIENT EMAIL		POSTAL CODE	
PRIMARY PHONE		SEC PHONE	
HEALTH CARD #		VC	DOB (YYYY-MM-DD)

PRE-PROCEDURE CLINICAL ASSESSMENT

UNAIDED VISUAL ACUITY	OD:	OS:
MANIFEST REFRACTION	OD:	OS:
CYCLOPLEGIC REFRACTION	OD:	OS:
KERATOMETRY	OD:	OS:
INTRAOCULAR PRESSURE (IOP)	OD:	OS:
PUPIL DIAMETER (DIM ILLUMINATION)	OD:	OS:
SLIT LAMP	OD:	OS:
FUNDUS	OD:	OS:

Contact Lens Use: SCL RGP PMMA Date of last use (YYYY-MM-DD) _____

Recommended Monovision YES NO Desired Outcome: OD _____ OS _____

Medical History (please list any active medical conditions, previous eye surgeries, diseases or injuries and any allergic reactions):

Comments/Questions:

Accessibility Requirements: _____