WATERLOO WELLINGTON Regional Coordination Centre

Waterloo Wellington Cataract Central Intake Referral Form
Regional Coordination Centre Local Fax Number: 519-621-0059
Toll-Free Fax Number: 1-833-583-2484
Telephone Number: 519-947-1000

** This form is for non-urgent cataract referrals only. For urgent referrals, follow standard procedures or contact 'on call' ophthalmologist **

Last Name:	First Name:	Gender: ☐Male ☐Female X
DOB (DD/MM/YY):	Phone (Primary):	Phone (Other):
Address:	City:	Postal Code:
Health Card #:	Social Barriers:	Language Barrier: ☐YES ☐NO
Height: Weight:	☐ Identifies as First Nations, Inuit, Metis	Language Spoken:
		Allergies: ☐NKA

MANDATORY* Information Section:

Patient Preference: *Please Check One*
☐ Shortest Wait ☐ Closest to Home ☐ Specific Surgeon:
☐ Other Preference:
☐ Patient willing to travel to neighbouring cities (Guelph, Cambridge, Kitchener)

Reason for Referral: *Select or Indicate*
☐ Routine Cataract ☐ Both Eyes (OU) ☐ Left Eye (OS) ☐ Right Eye (OD)
☐ Specialty IOL Implant ☐ Toric ☐ Multifocal ☐ Unsure
☐ Previous Corneal Refractive Surgery

OPTIONAL Information Section – *Please attach optometry report OR complete information below:*

☐ **Optometrist Report Attached**

☐ **Other Clinical Documentation Attached** (Ocular History, Systemic History, Referral Notes, Consultation Reports, Images, Visual Fields)

Current Refraction:
☐ Right Eye: ☐ BCVA:20/
☐ Left Eye: ☐ BCVA: 20/
Patient wears prism(s) in current spectacles
If so: ☐ Right prism:
☐ Left prism:

Current Eye Drops:

Current or Last IOP:
☐ Right Eye (mmHg):
☐ Left Eye (mmHg):

Current Contact Lenses:
☐ Patient wears contact lenses:
☐ Soft ☐ Rigid Gas Permeable ☐ Other:

Corneal Refractive Surgical History: ☐ No previous eye surgery
Type: ☐ LASIK ☐ PRK ☐ RK ☐ Unsure ☐ Other:
If LASIK or PRK: ☐ Myopia ☐ Hyperopia

Name of Surgeon: Approx Date (Year):

List Pre-Op Refraction and Ks (if known):
☐ Right Eye:
BCVA:20/ Ks: Refraction:

☐ Left Eye:
BCVA:20/ Ks: Refraction:

General Eye Surgical History:
☐ Patient has had previous eye surgery or laser treatment

☐ Right Eye Surgery Type:
Name of Surgeon: Approx Date (Year):
Other Notes:

☐ Left Eye Surgery Type:
Name of Surgeon: Approx Date (Year):
Other Notes:

Referring Provider Information*:
Name:
Address:
Phone: Fax:
OHIP Billing Number:

Signature: Date:

FOR INTERNAL USE ONLY
Ophthalmologist:

FOR MEDICAL SPECIALIST OFFICE STAFF USE ONLY
Ophthalmologist Consultation Date:

Save Referral | Print Referral | Clear Form

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