

# QHC Department of Ophthalmology – Referral Form

Date of Referral:

Patient Name:

DOB:

Address:

Home Phone:

Mobile Phone:

Health Card #:

Referring to:

Dr. Sakamoto

Dr. Davies

Dr. Safi

Dr. Lachapelle

Please use this form for **NON-URGENT** referrals only.

For **Emergent and Urgent referrals**, please contact the **ophthalmologist on-call by phone**.

REASON FOR REFERRAL:

Differential Dx:

√ Please attach copy of patient Cumulative Patient Profile and any relevant chart notes

**Ophthalmologic Relevant History:**

Cataract Surgery     Glaucoma     Retina History     Eye Trauma History

Has seen ophthalmologist in past. Who & Why? \_\_\_\_\_

Other? \_\_\_\_\_

**Ophthalmology Confirmation and Reply:**

ACCEPTED    Estimated Wait Time: \_\_\_\_\_

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 DECLINED     Urgent Case – Phone MD on call.     Wait times are too long.  
 Not enough information.     Outside my catchment area.  
 Has seen another ophthalmologist     Please refer to Dr. \_\_\_\_\_  
 Other: \_\_\_\_\_

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Dr. \_\_\_\_\_ MD FRCS

Date: \_\_\_\_\_