

PLEASE CIRCLE:
PHYSICIAN OR
NO PREFERENCE

Dr. Theodore

Rabinovitch

Cataract Surgery
Refractive Surgery
Cornea & Uveitis
LASIK/PRK

Dr. Seymour

Hershenfeld
Comprehensive

Dr. Tiiu Hess

Oculoplastics
Cataract Surgery

Dr. Tran Le

Cataract Surgery
Paediatric

Dr. Vlad Diaconita

Medical Retina

Dr. Tom Klein

Glaucoma
Cataract Surgery

Dr. Jon Waisberg

Dry Eye Disease
Cosmetic Botox

Dr. Farrah Moti

General
Cataract Surgery

Dr. David E. Lederer

Medical Retina

Dr. Gary Yau

Cataract Surgery
Specialty OD's

Dr. Sera Kwon

Dry Eye Disease
Cataract Care

Dr. Ken Wan

Glaucoma

No Preference

First Available

PLEASE INFORM PATIENT TO BRING CURRENT LIST OF MEDICATIONS, EYE DROPS & RX GLASSES
PLEASE ADVISE PATIENT OF TWO POSSIBLE APPOINTMENTS (PRELIMINARY TESTING & DOCTOR EXAMINATION)

Last Name:		First Name:	
Male/Female:	DOB (Y/M/D):	Cell #:	Home #:
Address:		Email:	
OHIP #:	Version Code:	Alternate contact:	
Reminder Preference:	<input type="checkbox"/> Email	<input type="checkbox"/> Text	<input type="checkbox"/> Voice call
Referring Doctor: <input type="checkbox"/> Dr.		OHIP Billing #:	
Address:		Postal Code:	
Email:	Fax:	Tel:	

GLAUCOMA	<input type="checkbox"/> High IOP	REFRACTIVE SURGERY	<input type="checkbox"/> Lasik/PRK Consult	CATARACTS	<input type="checkbox"/> OHIP Based Surgery
	<input type="checkbox"/> Disc Cupping		<input type="checkbox"/> Refractive Lens Exchange		<input type="checkbox"/> Premium IOL Selection
RETINA	<input type="checkbox"/> VF Field Loss	CORNEA	<input type="checkbox"/> Keratoconus/CXL	OCULOPLASTICS	<input type="checkbox"/> Refractive Cataract Surgery
	<input type="checkbox"/> Narrow Angles		<input type="checkbox"/> KScar / Edema / Other		<input type="checkbox"/> PCO
	<input type="checkbox"/> AMD DRY WET	INFLAMMATORY DISEASE	<input type="checkbox"/> Corneal Ulcer	BOTOX	<input type="checkbox"/> Chalazion/Lesion/Cyst/Lump
	<input type="checkbox"/> Hole/Tear/Detachment		<input type="checkbox"/> Pterygium		<input type="checkbox"/> Blepharoplasty Upper Lower Both
	<input type="checkbox"/> PVD/Floaters	TESTING	<input type="checkbox"/> Red Eye	NEURO	<input type="checkbox"/> Tearing
	<input type="checkbox"/> Retinal Lesion		<input type="checkbox"/> Episcleritis/Scleritis		<input type="checkbox"/> Entropion/Ectropion/Ptosis
	<input type="checkbox"/> Diabetic Retinopathy		<input type="checkbox"/> Uveitis/Iritis	DRY EYE	<input type="checkbox"/> Blepharospasm
	<input type="checkbox"/> Macular Edema	<input type="checkbox"/> Visual Field/OCT/OPTOS	<input type="checkbox"/> Pentacam Topography		<input type="checkbox"/> Cosmetic/Fillers
	<input type="checkbox"/> Vein Occlusion		OD OS OU		<input type="checkbox"/> Optic Nerve (Drusen, Pallor)
	<input type="checkbox"/> Choroidal Nevus				<input type="checkbox"/> Diplopia
	<input type="checkbox"/> ERM				<input type="checkbox"/> Cranial Nerve Palsy
	<input type="checkbox"/> _____				<input type="checkbox"/> Thyroid Abnormalities
	<input type="checkbox"/> _____				<input type="checkbox"/> Dry Eye Analysis/Treatment
	<input type="checkbox"/> _____				<input type="checkbox"/> LIPIFLOW/IPL
	<input type="checkbox"/> _____				*Are you currently managing your patients' dry eye? YES or NO

	OD	OS
BCVA		
REFRACTION		
IOP		

Additional Information:

PLEASE CIRCLE: LOCATION PREFERENCE

2065 Finch Ave. Suite 400
Downsview, Ontario M3N 2V7
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Toronto, ON M2N 6R6
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