BOCHNER
EYE • INSTITUTE

HAROLD A. STEIN, FRCSC
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Referral Form

SEND TO:	The Bochner Eye Institute
FAX:	☐ TORONTO (416) 966-8917 bochner@bochner.com
	☐ SCARBOROUGH (416) 439-9523 scarborough@bochner.com
	☐ UNIONVILLE (905) 470-2216 unionville@bochner.com
TELEPHONE:	(416) 960-2020 • 1-800-665-1987

Patient Information	Name: (please print)	Last	First	Mi
Address:		City	Province/State	Zip/Postal Code
Phone: Daytime ( )		Evening ( )	Email:	
Ocupation		Birthdate M___ / D___ / Y___	Sex (Check) M ❑ F ❑	

Scheduling Information	Referred to:		
	Date:	M_____ / D_____ / Y_____	Procedure:

Pre-Procedure Assessment	**OD**	**OS**
Unaided Visual Acuity	20/	20/
Manifest Refraction	20/	20/
Cycloplegic Refraction	20/	20/
Keratometry	Flat K @ Axis Steep K @ Axis	Flat K @ Axis Steep K @ Axis
IOP	mm Hg	mm Hg
Slit Lamp	Check: Normal Abnormal Comment	Check: Normal Abnormal Comment
Pupil diameter (dim illumination)	mm	mm
Fundus	☐ Normal ☐ Abnormal Comment	☐ Normal ☐ Abnormal Comment

Contact Lens Use	Check: SCL ❑ RGP ❑ PMMA ❑ Date of last use: M___ / D___ / Y___

Medical History	
	Medical conditions:
	Current medications (if applicable):
	Previous eye surgeries, diseases, injuries:
	Allergic reactions (medications/solutions):

Recommended Procedure	Check: PRK ❑ LASIK ❑ RLE ❑ ICL ❑ INTACS ❑	OD OS OU
Recommended Monovision	Check YES ❑ NO ❑	Desired Outcome: OD OS

Comments/Questions
(Use and send reverse side if needed)

REFERRING DOCTOR	Name: (please print)	Phone: ( )
Location:		Fax: ( )
Signature:	Email:	Date: M___ / D___ / Y___