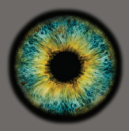
BOCHNER
EYE • INSTITUTE



RAYMOND STEIN, FRCSC
FATIMAH GILANI, FRCSC
ALBERT CHESKES, FRCSC

Referral Form

SEND TO: The Bochner Eye Institute

FAX: ☐ TORONTO (416) 966-8917 bochner@bochner.com
☐ UNIONVILLE (905) 470-2216 unionville@bochner.com
☐ SCARBOROUGH (416) 439-9523 scarborough@bochner.com
☐ OAKVILLE (905) 845-7828 oakville@bochner.com

PHONE: (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 (Ant. Segment)	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 ❑	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 ❑ CXL ❑	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: ( ) Fax: ( )
Location:		
Signature:	Email:	Date: M___ / D___ / Y___