



## OPHTHALMOLOGISTS / OPTOMETRISTS REFERRAL FORM

**\*\* A recent eye report can be submitted in lieu of this form\*\***

Patient Name: \_\_\_\_\_ Referring MD/OD: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Exam: \_\_\_\_\_  
 City: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Fax: \_\_\_\_\_  
 BC Medical # \_\_\_\_\_  
 Ocular Diagnosis: \_\_\_\_\_  
 Systemic Diagnosis: \_\_\_\_\_

**Visual Function Complaints:**     Photophobia     Nyctalopia     Blur     Mobility  
     Colour     Other (please list) \_\_\_\_\_  
**Previous Low Vision Evaluation:**     Yes     No    Date/Location (if available) \_\_\_\_\_

**EXAMINATION**

**Vision:**     with glasses     without glasses

	Distance	Near
<b>OD</b>		
<b>OS</b>		
<b>OU</b>		

**Refraction / Current Glasses:**

Manifest \_\_\_\_\_ OD  
 Cycloplegic \_\_\_\_\_ OS  
 Current Glasses  
 None \_\_\_\_\_ OD  
 \_\_\_\_\_ OS  
 Date of Last Eye Exam: \_\_\_\_\_

Teller Cards     Snellen     Lea     Allen     Other \_\_\_\_\_

If normal, please ✓ box. If abnormal, please describe:

Pupils: \_\_\_\_\_  
 Motility: \_\_\_\_\_  
 Anterior Segment: \_\_\_\_\_  
 Fundus: \_\_\_\_\_

**Testing and Results** (if abnormal, please describe)

Test	Normal	Not Performed	Results:
ERG	<input type="checkbox"/>	<input type="checkbox"/>	_____
VEP	<input type="checkbox"/>	<input type="checkbox"/>	_____
COLOUR	<input type="checkbox"/>	<input type="checkbox"/> Test type:	<input type="checkbox"/> Ishihara <input type="checkbox"/> Chip test (i.e. Dis) <input type="checkbox"/> Hardy Rand Rittler
OTHER (please specify)	_____		