



**Dynamic Medical Care**

Level 2 Surgical & Medical Centre  
6519 Mississauga Road,  
Mississauga, ON L5N 1A6

Phone #: 905-542-7865  
Fax #: 905-813-1440

**Optometrist Referral Form**

Referring Doctor: _____	OHIP Billing #: _____
Office Phone: _____	Fax #: _____ Email: _____

Patient Last Name: _____	First Name: _____	Male/Female/Other: _____
DOB (Y-M-D): _____	Address: _____	City: _____ Postal Code: _____
HC #: _____	Version Code: _____	Phone/Email: _____

Clinical Complaint:	VA: OD _____ OS: _____
	IOP: OD _____ OS: _____

**REASON FOR REFERRAL:** Please indicate consult (Routine / ASAP / Urgent)

- Cataract Surgery
- Laser PI for Narrow angle
- Laser Yag Capsulotomy
- Retinal Lasers: Barrier / Focal / PRP / Grid
- Glaucoma SLT Laser
- ARMD: dry / wet / anti-VEGF

- Retinal Screening exam DM / HTN / HCQ
- Glaucoma suspect / Management
- Flashes and Floaters (Retinal Tears)/PVD
- Eyelid Problems: Entropion / Ectropion
- Visual Loss / Deterioration
- Ophthalmic Screening & Dry Eye exam

**Note:**

- Please ensure patient has a driver.
- Allow 90 minutes for initial consultation DFE.
- **If urgent call office to talk to doctor before sending patient.**

**Doctor Signature:** \_\_\_\_\_

**Billing Number:** \_\_\_\_\_