Erie St. Clair and SW Ontario Cataract Central Intake Referral Form

Cataract Central Intake Fax Number: 519-646-6368
Telephone Number: 519-646-6100 ext.61680
Email: SJHCCataractCentralIntake@sjhc.london.on.ca

** Central Intake will only accept non-urgent referrals for Cataract Surgery **

Last Name:	First Name:	Sex: ☐ Male ☐ Female ☐ X _____
DOB (DD/MM/YY):	Phone (Primary):	Phone (Other):
Address:	City:	Postal Code:
Health Card #:	☐ Social Barriers:	Language Barrier: ☐ YES ☐ NO
Height: Weight:		Language Spoken:
		Allergies: ☐ NKA

MANDATORY* Information Section:

Patient Preference: *Please Check One*	☐ Shortest Wait	☐ Closest to Home	☐ Specific Surgeon:	
	☐ Other Preference:			
	☐ Patient willing to travel to neighbouring cities within region			
Reason for Referral: *Select or Indicate*	☐ Routine Cataract	☐ Both Eyes (OU)	☐ Left Eye (OS)	☐ Right Eye (OD)
	☐ Specialty IOL Implant	☐ Toric	☐ Multifocal	☐ Unsure
	☐ Previous Corneal Refractive Surgery			

OPTIONAL Information Section – *Please attach optometry report OR complete information below:*

☐ **Optometrist Report Attached**	☐ **Other Clinical Documentation Attached** (Ocular History, Systemic History, Referral Notes, Consultation Reports, Images, Visual Fields)
Current Refraction: ☐ Right Eye: ☐ BCVA:20/ ☐ Left Eye: ☐ BCVA: 20/ ☐ Patient wears prism(s) in current spectacles If so: ☐ Right prism: ☐ Left prism: **Current Eye Drops:**	**Current or Last IOP:** ☐ Right Eye (mmHg): ☐ Left Eye (mmHg): **Current Contact Lenses:** ☐ Patient wears contact lenses: ☐ Soft ☐ Rigid Gas Permeable ☐ Other:
Corneal Refractive Surgical History: ☐ No previous eye surgery Type: ☐ LASIK ☐ PRK ☐ RK ☐ Unsure ☐ Other: If LASIK or PRK: ☐ Myopia ☐ Hyperopia Name of Surgeon: Approx Date (Year): List Pre-Op Refraction and Ks (if known): ☐ Right Eye: BCVA:20/ Ks: Refraction: ☐ Left Eye: BCVA:20/ Ks: Refraction:	**General Eye Surgical History:** ☐ Patient has had previous eye surgery or laser treatment ☐ Right Eye Surgery Type: Name of Surgeon: Approx Date (Year): Other Notes: ☐ Left Eye Surgery Type: Name of Surgeon: Approx Date (Year): Other Notes:

Referring Provider Information*: Name: Address: Phone: Fax: OHIP Billing Number:	**FOR INTERNAL USE ONLY** Ophthalmologist: **FOR MEDICAL SPECIALIST OFFICE STAFF USE ONLY** Ophthalmologist Consultation Date:
Signature: Date:	