clarity eye

Consultation

Patient Information

Name: _____ Male ☐ Female ☐ DOB (yy/mm/dd): _____

Home Phone: _____ Other: _____

Address: _____ Unit #: _____ City: _____ Postal Code: _____

Healthcard: _____ Version Code: _____

Email: _____

Reason for Referral

Cataracts (OHIP Surgery ☐ Premium IOL ☐ Undecided ☐) Narrow Angles ☐ Glaucoma ☐ Diabetic Check ☐

Wet AMD ☐ CRVO/BRVO ☐ Dry Eye/CODEC Other: _____

MEDICATION*	OD (RIGHT)	OS (LEFT)
Best Corrected VA		
Refraction		
IOP		
CCT		

Comments: _____

Referring Doctor's Name: _____ Provider #: _____

Phone: _____ Fax Back #: _____

Family Doctor: _____

Preferred Consult Location:

☐ **Ajax**
145 Kingston Road E.
Unit #3

☐ **Brampton**
350 Rutherford Road
South Suite 300 Plaza II

☐ **Midtown**
1849 Yonge Street
Suite 705

☐ **Newmarket**
130 Mulock Drive
Unit 3

☐ **Roncesvalles**
2238 Dundas Street W
Suite 308

☐ **Scarborough**
2855 Markham Road
Suite 408

☐ **Vaughan**
9135 Keele Street
Unit A5

Please fax to 416-663-3731 or email referrals@clarityeye.ca

Please inform your patient to allow 1 ½–2 hours for consultation visits. Sunglasses are advisable.
Patients will have eye drops instilled that may cause vision to blur and be sensitive to light.

Our vision is excellence.

Phone 416-663-3937 Fax 416-663-3731