3280 BLOOR STREET WEST, SUITE 310

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VITREOUS RETINA MACULA
SPECIALISTS OF TORONTO

DATE: _____

REFERRING PROVIDER: _____ CLINIC NAME: _____

CLINIC EMAIL: _____

CLINIC PHONE: _____ CLINIC FAX _____

LICENSE NO: _____ OHIP NO:_____

ADDRESS: _____

PATIENT NAME: _____ M / F DOB: ____/____/_____ (mm-dd-yyyy)

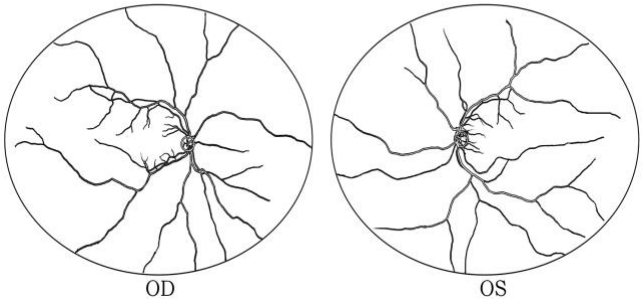
EMAIL ADDRESS: _____

OHIP NO: _____ VERSION CODE: _____ EXP: _____

ADDRESS:_____

CELL PHONE: _____ HOME PHONE: _____

Please mark any areas of interest outside of the macula



URGENT ☐ NON-URGENT ☐

Notes:

PLEASE CHECK ALL THAT APPLY: **OD OS OU**

☐ ARMD ☐WET ☐ DRY

☐ CATARACT ☐ DME ☐ PDR

☐ CENTRAL SEROUS RETINOPATHY

☐ DIABETIC RETINOPATHY ☐ MACULAR PUCKER

☐ FLASHES/FLOATERS/POSTERIOR VITREOUS DETACHMENT

☐ HIGH MYOPIA/MYOPIC DEGENERATION ☐ RETINAL VEIN OCCLUSION ☐ MACULAR HOLE

☐ RETINAL TEAR/RETINAL DETACHMENT

☐ OTHER_____