FAMILY EYE CARE

Knowledge of past and present family eye disease can help you save your vision. Certain eye diseases, such as glaucoma and Are-Related Macular Degeneration (AMD) run in families. Symptoms progress so gradually that they often go unnoticed. If you have a family history of eye disease, please use our self-referral form to book an appointment with one of our doctors.

There are many reasons why we all need to see an eye specialist on a regular basis:

- Many systemic diseases can affect the eye
- Some conditions of the eye are silent in nature and do not present signs or symptoms until a later stage
- Many hereditary eye diseases progress without any warning signs at all
- You may not be aware of some changes to your eyes that, if properly assessed at an early stage, may prevent potential long term damage
- If Age-Related Macular Degeneration is in your family history, you have up to 50% chance of developing the disease
- In adults, glaucoma and Age-Related Macular Degeneration are the two leading causes of blindness which appear to be inherited
- Nearly two-thirds of people affected by vision loss are female
- Elderly individuals of African ancestry are five times more likely to develop glaucoma

You can also use our self-referral form to book an appointment with us if you:

- Have a family history of eye disease such as Glaucoma or Age-Related Macular Degeneration
- Have a family history of diabetes
- Have used Steroids, Amiodarone, Plaquenil or Chloroquine
- Have a history of Systemic Lupus
- Erythematosus
- Have eye glass prescriptions greater than 4D of power in either eye
- Are greater than 65 years of age
- Are experiencing decreased night vision
- Are experiencing eye lid abnormalities such as lid bumps and discolourations

1880 Sismet Road,
Mississauga, ON, L4W1W9

CONTACT US

Use the Online Portal
www.occeyecare.ca

VS. Q2 2024

OCC eyecare

Family Eye Care & Self Referral Form

OCC Eyecare

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Patient Self-Referral Form

Thank you for requesting an appointment with one of our doctors. Please note that completion of this form does not guarantee an appointment as requested. Please ensure all fields are completed below including patient name and a daytime phone number. Incomplete forms will not be processed.

Patient Name: _____ Email: _____

Patient Address: _____ City: _____ Postal Code: _____

DOB (mm/dd/yyyy): _____ OHIP#: _____ Version Code: _____

Check if requesting a specific doctor (optional)

☐ Dr. F. Ali ☐ Dr. N. Armogan ☐ Dr. N. Gill ☐ Dr. K. McGuire
☐ Dr. D. Yan ☐ Dr. D. DeAngelis ☐ Dr. A. Kosaric ☐ Any Available

Reason for referral:

☐ Glaucoma or Cataract
☐ Family History of Glaucoma
☐ High Cholesterol or Blood Pressure
☐ Family History of Macular Degeneration
☐ Other:_____

☐ Eyelid Problems
☐ Watery Eyes
☐ Macular Degeneration
☐ Diabetes
☐ ICL

Please indicate if you have any of the following medical conditions:

☐ Diabetes
☐ Thyroid Disease
☐ High Blood Pressure
☐ Kidney Problems
☐ Cholesterol
☐ Asthma
☐ Heart Disease
☐ Blood Related Diseases
☐ Rheumatic Disease

Please attach a CPP from your family doctor & list of medication from your pharmacy:

Briefly outline your eye health history: