OCC eyecare, Inc.

1880 Sismet Rd. Mississauga, Ontario L4W 1W9
Phone: +1.905.212.9482 Fax: +1.905.212.1012
www.occeyecare.ca
info@occeyecare.ca

Patient Self-Referral Form

Thank you for requesting an appointment with one of our specialists. All referrals will be examined within 2 working days of our receiving this form. Please note that completion of this form does not guarantee an appointment as requested. If you have not been notified of an appointment date within one week, please contact our office. Please ensure all fields are completed below including patient name and a daytime phone number. Incomplete forms will not be processed. Faxing of this form is recommended.

Patient Name: _____ Phone #: _____

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. V. Lam
☐ 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
☐ LASIK

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 list your current medications:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Please list current Doctor's name, phone and fax number:

Dr. _____ Phone: _____ Fax: _____

Dr. _____ Phone: _____ Fax: _____

For Office Use Only

Doctor Approved: ☐ Yes ☐ No
Time Line: ☐ Week ☐ Month
☐ AM ☐ PM

Age Appropriate: ☐ Yes ☐ No
Existing OCC Patient: ☐ Yes ☐ No

Patient to obtain records from: ☐ Optometrist ☐ Other Doctor(s): _____

Doctor Signature: _____ Date: _____