HERZIG EYE INSTITUTE

TORONTO | OTTAWA

Clear Form

Cataract Consultation Form

PH: 416-929-2020 (Toronto) 613-800-1680 (Ottawa)
Fax: 416-929-0232 (Toronto) 613-800-0718 (Ottawa)

Referral to Doctor: _____

Patient Name:		**DOB:**	**Age:**
Address:	**City:**	**Postal:**	
Home Phone:	**Cell Phone:**		
Email:			
HC:	**VC:**	**Gender:**	

Medical Hx / Allergies: _____

Comments: _____

Exam Date: _____

Present Correction

OD _____ _____ X ____ 20/

OS _____ _____ X ____ 20/

IOP

OD _____

OS _____

Dominant Eye

☐ OD

☐ OS

Slit Lamp Exam

OD **OS**

Fundus Exam

OD **OS**

Patient Interested in Refractive Cataract Surgery? ☐ **Yes** ☐ **No**

Referring Doctor:		**Billing Number:**
Address:		**Meeting Date:**
Phone:	**Fax:**	**Surgery Date:**
Email:		**Comments:**