HERZIG
EYE INSTITUTE
TORONTO | OTTAWA

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: ____

Exam Date: ______________________

Wearing CL today? Yes **Type:** Soft Hard RGP **Date Last Worn:** _____________

UCVA
OD 20/
OS 20/

Present Correction **(Age of Rx: __________)**
OD _______ _______ X ____ 20/
OS _______ _______ X ____ 20/

Dominant Eye
OD
OS

Manifest Refraction
OD _____ _____ X _____ 20/
OS _____ _____ X _____ 20/

Cycloplegic Refraction
OD _____ _____ X _____ 20/
OS _____ _____ X _____ 20/

Pupil Size
OD ______ / ______
OS ______ / ______
Bright Dim

Corneal Thickness
OD ____________
OS ____________

IOP
OD ______
OS ______

Monovision Discussed: YES NO **Comments:** ____________________________________

Slit Lam Examination:

OD **OS**

Fundus: **Fundus:**

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