Consultation Request

Haute Vision
OPHTALMOLOGIE

5301, av. de Courtrai, # 311
Montréal QC H3W 0B1

Haute Vision Clinic
T. (514) 782-8282
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fax@hautevision.com

hautevision.com

Dr. Johanna Choremis
Specialist in Cornea, Anterior Segment, Complex Cataract, and Refractive Surgery

Dr. Julia Talajic
Specialist in Cornea, Anterior Segment, Complex Cataract, and Refractive Surgery

Dr. Elise Slim
General Ophthalmologist and Anterior Segment Surgery Specialist

Dr. David Silver
Ophthalmologist

Dr. Marc Mullie
Ophthalmologist

Dr. Ghassan Cordahi
Specialist in Retina and Posterior Segment

Dr. Taylor Nayman
Specialist in Glaucoma and Cataract Surgery

Dr. Vanessa Bachir
Optometrist

Dr. Charlotte Monette
Optometrist Specialized in Contact Lenses

Dr. Jamie Wong
Oculoplastic Surgeon and Eyelid Specialist

Dr. Julie Caron
Optometrist

REFERRING TO: **Date:**

☐ Specify: Dr :

☐ **No Preference for Doctor** / Please assign according to availability

PATIENT DETAILS: Gender: ☐ M ☐ F **RAMQ #:**

First Name: Last Name: Tel. #1:

Address: Tel. #2:

Date of birth:

REFERRAL REASON:
Please complete all relevant details and **email** or fax the form. Emails are preferred at **fax@hautevision.com**

☐ **General** ☐ **Cataract** ☐ **Retina** ☐ **Glaucoma** ☐ **Cornea** ☐ **Dry Eyes**
☐ **Advanced Dry Eye Therapy** (IPL, RF, amniotic membrane, PRP drops, scleral lenses)
☐ **Oculoplastics/Esthetics** (blephs, lid lesions, xanthelasma, injections, rejuvenation)
☐ **Refractive Surgery** (refractive lens exchange, LASIK/PRK, EVO/intraocular contact lens)
☐ **Other**

☐ Loss of vision ☐ OD ☐ OS ☐ OU ☐ Gradual ☐ Sudden ☐ Transient ☐ Constant ☐ Curtain
How long and since when? ____ Days ____ Weeks ____ Months ____ Years

☐ Pain
☐ Flashes of light
☐ New floater(s)
☐ Metamorphopsia / Distortion
☐ Photophobia
☐ Tearing
☐ Foreign body sensation
☐ Itching and burning
☐ Redness
☐ Swollen lids
☐ Discharge

OD	**Visual Acuity** 20/	**IOP**	**OS**	**Visual Acuity** 20/	**IOP**

Clinical information:

Previous ocular surgery / disease:

Clinic use only ☐ Refused
Date of receipt:
Triage performed by:

Please attach any relevant examination results to this consultation request.

REFERRED BY:

Last Name (block letters): First Name (block letters):

License #: **Fax #:**

Signature: