Haute Vision
OPHTALMOLOGIE

Haute Vision Clinic
T. 514 782-8282 **F.** 514 788-6499
fax@hautevision.com

5301, avenue de Courtrai, bureau 311
Montréal (Québec) H3W 0B1

CONSULTATION REQUEST

www.hautevision.com

REFERRING TO: **Date:**

☐ Specify: Dr :

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

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

First Name: Tel. #1:

Last Name: Tel. #2:

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

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: