Ophthalmology Referral Form

If this patient needs to be assessed within 7 days, you must:
CALL OPHTHALMOLOGIST ON CALL — DO NOT USE THIS REFERRAL.
Also, as visual acuity is the vital sign of the eye, the expectation is that this will be completed during in person visits and charted below.
To take a Visual Acuity without a paper Snellen Chart, download the Eye Chart app (iPhone) or WHOeyes app (Android) and follow instructions.
Please indicate below if the visit was virtual or in person. Thank you.

PATIENT'S HOME ZONE

◯ Eastern Urban ◯ Eastern Rural ◯ Western ◯ Central ◯ Labrador-Grenfell

HOW DID YOU ASSESS THE PATIENT?

◯ In Person Visit ◯ Virtual

VISUAL ACUITY EXAM RESULTS (complete for In Person Visit)

Right Eye:

◯ 20/15 ◯ 20/20 ◯ 20/25 ◯ 20/30 ◯ 20/40 ◯ 20/50 ◯ 20/60 ◯ 20/70 ◯ 20/80 ◯ 20/100 ◯ 20/150 ◯ 20/200
◯ 20/300 ◯ 20/400 ◯ Counting fingers at 1' ◯ Counting fingers at 3' ◯ Counting fingers at 6' ◯ Hand Movements
◯ Light Perception ◯ No Light Perception

Left Eye:

◯ 20/15 ◯ 20/20 ◯ 20/25 ◯ 20/30 ◯ 20/40 ◯ 20/50 ◯ 20/60 ◯ 20/70 ◯ 20/80 ◯ 20/100 ◯ 20/150 ◯ 20/200
◯ 20/300 ◯ 20/400 ◯ Counting fingers at 1' ◯ Counting fingers at 3' ◯ Counting fingers at 6' ◯ Hand Movements
◯ Light Perception ◯ No Light Perception

REFERRAL CATEGORY (select one — complete matching section on pages 2–3)

◯ Cataract ◯ Cornea ◯ Diabetic Retinopathy ◯ Eyelids ◯ Glaucoma ◯ Retina
◯ Strabismus ◯ YAG Capsulotomy Procedure ◯ Dry Eyes ◯ Plaquenil Screening
◯ **Other (specify):** _____

CATEGORY-SPECIFIC FIELDS (complete the block matching your selection on page 1)

A — CATARACT

Reason for Referral (select one):

◯ Cataract + Low Impact on Functionality ◯ Cataract + High Impact on Functionality

Cataract Laterality:

◯ Left ◯ Right ◯ Bilateral

B — CORNEA

Reason for Referral (select one):

◯ Corneal Abrasion ◯ Corneal Infection/Ulcer (EYE EMERGENCY — CONSULT OPHTHALMOLOGIST ON CALL) ◯ Pterygium

◯ Dry Eye ◯ Cloudy Cornea ◯ Corneal Dystrophy ◯ Keratoconus

Cornea Laterality:

◯ Left ◯ Right ◯ Bilateral

C — DIABETIC RETINOPATHY

How long has patient been a diabetic?

_____

Type of Diabetic:

◯ Type I ◯ Type II

Previous Intraocular Injections:

◯ Yes ◯ No

D — EYELIDS

Reason for Referral (select one):

◯ Lesion (suspected malignancy) ◯ Lesion (benign) ◯ Visual Axis Obscured ◯ Stye/Chalazion ◯ Droopy Eyelid ◯ Other

If 'Droopy Eyelid' selected — Direction:

◯ Inward turning ◯ Outward Turning

Eyelids Laterality:

◯ Left ◯ Right ◯ Bilateral

E — GLAUCOMA

Reasons for Referral (select all that apply):

☐ Glaucoma + IOP 20-30

☐ Glaucoma + IOP > 30

☐ Glaucoma + IOP >38 (EYE EMERGENCY — CONSULT OPHTHALMOLOGIST ON CALL)

☐ Glaucoma + IOP < 20

☐ Narrow Angles

CD Ratio OS (If known):

_____

CD Ratio OD (If known):

_____

Intraocular Pressure (mmHg) OD (If known):

_____

Intraocular Pressure (mmHg) OS (If known):

_____

Glaucoma Laterality:

◯ Left ◯ Right ◯ Bilateral

Family History of Glaucoma: ◯ Yes ◯ No

Is patient taking medication or drops for Glaucoma: ◯ Yes ◯ No

Has patient had previous laser for Glaucoma: ◯ Yes ◯ No

Has patient had previous surgery for Glaucoma: ◯ Yes ◯ No

Has patient been followed previously by an Ophthalmologist for Glaucoma: ◯ Yes ◯ No

F — RETINA

Reason for Referral (select one):

◯ Flashes and/or Floaters ◯ Retinal hole/tear ◯ Macular Degeneration ◯ Vein Occulsion

◯ Retinal Detachment (EYE EMERGENCY — CONSULT OPHTHALMOLOGIST ON CALL)

# of Floaters (approximate): _____

Retina Laterality:

◯ Left ◯ Right ◯ Bilateral

Previous Intravitral Injections:

◯ Yes ◯ No

G — STRABISMUS

Reason for Referral (select one):

◯ Strabismus + Double Vision ◯ Strabismus + symptom other than double vision

Strabismus Laterality:

◯ Left ◯ Right ◯ Bilateral

Onset of Strabismus (select one):

◯ Acute Onset (DISCUSS WITH OPHTHALMOLOGIST ON CALL) ◯ Longstanding Onset

H — YAG CAPSULOTOMY PROCEDURE

When did the patient have cataract surgery?

_____

Which eye:

◯ Left Eye ◯ Right Eye

I — DRY EYES

Does the patient use medication or drops for dry eyes — if so, describe:

_____

Does the patient have Rheumatoid Disease — if yes, elaborate:

_____

J — PLAQUENIL SCREENING

Dosage of Plaquenil:

_____

How long has patient been taking Plaquenil?

_____

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ALL REFERRALS — COMPLETE FOR EVERY CATEGORY

Symptoms (select all that apply):

- ☐ Blurred vision
- ☐ Double vision
- ☐ Floaters
- ☐ Eyelid Swelling
- ☐ Red Eye(s)
- ☐ Eye pain/discomfort
- ☐ Glare
- ☐ Halos
- ☐ Foreign Body
- ☐ Other
- ☐ Flashes
- ☐ Photophobia
- ☐ Discharge/Pus
- ☐ Decreased Vision

If 'Other' symptoms — Explain: _____

Previous eye surgery?

○ None ○ 0-12 days ○ 13-30 days ○ 1-3 months ○ > 3 Months

If not 'None' — complete below:

Name of Surgeon: _____

Type of eye surgery: _____

Date of eye surgery: _____

Laterality:

○ Right Eye ○ Left Eye

Are activities of daily living affected: ○ Yes ○ No

Is the patient driving: ○ Yes ○ No

Previous Retinal Laser: ○ Yes ○ No

Referral Type:

○ New Referral ○ Update to Existing Referral

Comments:

_____

_____