TORONTO RETINA INSTITUTE - REFERRAL FORM

NORTH YORK	**fax: (416) 449-0874**	ph: (416) 449-3937
OSHAWA	**fax: (1-833) 636-1551**	ph: (1-833) 636-1550
OAKVILLE	**fax: (647) 478-2403**	ph: (647) 478-2402

1. URGENCY	2. LOCATION and PHYSICIAN		3. ISSUE
	NORTH YORK	**OSHAWA**	
❑ Urgent	❑ **First Available**	❑ **First Available**	❑ Retinal tear/detachment/hole
❑ Semi-Urgent	❑ Alan Berger	❑ Shaheer Aboobaker	❑ Dry/Wed AMD
❑ Elective	❑ David Chow	❑ Parnian Arjmand	❑ Macular hole/pucker
	❑ Keyvan Koushan	❑ Nirojini Sivachandran	❑ CRVO/BRVO
	❑ Shaheer Aboobaker		❑ CME
	❑ Alex Kaplan	**OAKVILLE**	❑ Diabetic check
	❑ Mark Mandell	❑ **First Available**	❑ **Other** (please specify):
	❑ Fatima Gilani	❑ Shaheer Aboobaker	
	❑ Parnian Arjmand	❑ Nirojini Sivachandran	
	❑ Nirojini Sivachandran	❑ Parnian Arjmand	
	❑ Carol Schwartz	❑ Keyvan Koushan	
	❑ Nancy Tucker		

Referring Doctor Name: ______________________ Billing #: ______________________

Telephone: ______________________ Fax Back: ______________________

Comments: ____

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Patient Last Name: ______________________ Patient First Name: ______________________

Telephone Home: ______________________ Cellphone: ______________________

DOB (mm/dd/yyyy): ______________________ Health Card #: ______________________

Email (if patient consents to communicate via email): ______________________