



# vista eye centre

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**CONSULTATION REQUEST FORM** (Please fax to 647-689-2276)

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Home Telephone #: \_\_\_\_\_ Office Phone #: \_\_\_\_\_  
Mobile #: \_\_\_\_\_ Email address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
DOB: \_\_\_\_\_ YY/MM/DD Health Card #: \_\_\_\_\_ Version Code: \_\_\_\_\_

**REASON FOR REFERRAL:**  Right eye  Left eye

- CATARACT  Early cataract  Ready for surgery  PCO (posterior capsule opacification)
- GENERAL  Blurred vision  Eye pain discomfort  Flashes & Floaters
- ANTERIOR SEGMENT  Cornea  Dry Eye/Blepharitis  Red eye  Iritis
- GLAUCOMA  Glaucoma  High IOP  Disc cupping  Narrow angles
- RETINA  Diabetes  ARMD (dry/wet)  Retina hole/tear  Vein Occlusion
- OCULOPLASTICS  Eyelid lesions  Ptosis/droopy lids  Tearing
- OTHER: \_\_\_\_\_

	OD	OS
Best corrected VA		
Refraction		
IOP		
Exam Findings:		

**MEDICAL URGENCY:**  Routine - Next available  Urgent

**Referring Doctor:** \_\_\_\_\_ OHIP Billing #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Office phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Thank you for your referral.**

Your office will be notified by fax of your patient’s appointment. Please complete all fields above to avoid a delay in bookings. A demographic label is preferred for patient information.

**DISCLAIMER:** Please note that VISTA Eye Center does not assume the care of the patient until seen by one of our ophthalmologists. If you believe your patient needs to be seen more urgently, please speak with us directly or arrange for your patient to go to the nearest emergency room

[vistaeyecentretoronto.com](http://vistaeyecentretoronto.com)