



vista eye centre

Dr. Larissa A. Derzko-Dzulynsky, MD, FRCSC
Dr. Nupura K. Bakshi, MD, FRCSC
Dr. Tiiu Hess, MD, FRCSC

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