euclid TELEHEALTH
eye disease assessments
IN COLLABORATION WITH THE GALEN EYE CENTRE

REFERRAL FORM

Please help us to speed up your patient's journey by including all supporting information.

PATIENT INFORMATION

Last Name: _____ First Name: _____

DOB (YYYY/MM/DD _____ Sex: ◯ F ◯ M ◯ Other

OHIP Number _____ Version Code _____ Expiration Date: _____

Patient Home Address: _____

Patient Contact Information: _____

Patient Alternate Contact Information: _____

Patient E-mail address: _____

Does the patient have special needs? ◯ Yes ◯ No

If yes, please specify:

◯ Oxygen ◯ Wheelchair ◯ Stretcher ◯ Transfer Service

◯ Interpretation – Language _____ ◯ Other: _____

REASON FOR REFERRAL

◯ Eye Disease Screening age 40 or older
◯ Diabetic
◯ Family history of eye disease

Patient experiencing any of the following:
◯ Blurred vision
◯ Gradual change in vision
◯ Increased difficulty driving at night

Additional Information:

Please specify: ◯ **Urgent** ◯ **Semi-Urgent** ◯ **Next available**

Signature of Referring Physician/Nurse Practitioner: _____
OHIP Billing Number: _____
Date: (YYYY/MM/DD) _____

E info@euclidtelehealth.org **T** 1-800-511-5661 F 1-613-417-3333 www.euclidtelehealth.org