DR. KATHY CAO Ophthalmologist Referral Form
Tel: (416) 901-5588 | Fax: (647) 417-7098
Suite 202, 1333 Sheppard Ave East, M2J 1V1

Patient Info

Last Name:_____ First Name:_____ Phone:_____

OHIP #:_____ Version Code: _____ DOB: Y_____ M_____ D_____

Address:_____ City:_____ Postal Code:_____

Patient email: _____

Language preference: [ ] English [ ] Mandarin [ ] Cantonese [ ]Other:_____

Referring Doctor Info

Referring doctor:_____ OHIP Billing #:_____

Address:_____ City:_____ Postal Code:_____

Phone:_____ Fax:_____

Urgency: [ ] Same Day [ ] Same Week [ ] Routine (next available)

Reason for referral (please tick where applicable):

Cataract	[ ] OD [ ] OS [ ] OU [ ] Ready for surgery [ ] Unsure [ ] PCO (posterior capsular opacification) [ ] Premium options discussed: [ ] Femto laser cataract surgery [ ] IOL Master [ ] Premium lens package [ ] Astigmatism correction
Glaucoma	[ ] Narrow angles [ ] High IOP [ ] Disc cupping [ ] Field loss
Retina	[ ] AMD: [ ] Wet [ ] Dry [ ] Vein occlusion [ ] Diabetic retinopathy [ ] Retinal breaks [ ] PVD/Floaters
Cornea	[ ] Pterygium [ ] Keratoconus [ ] Dry eye
Other	[ ] Iritis [ ] Chalazion [ ] Other:
Notes	

Please fax this form to **(647) 417-7098**
or complete our online referral form on
drkathycao.com/referral

Eye Exam	OD	OS
BCVA		
Refraction		
IOP		