Paediatric Ophthalmology and Adult Strabismus Referral

McMaster Children's Hospital 1200 Main St W. Hamilton ON L8N 3Z5
Call: 905-521-2100 ext. 72400

DATE: ______________________ **FAX to: 905-521-2332**

PATIENT NAME: ______________________ **DOB**: ______________________

***Health Card:** ______________________ (OHIP) Male ☐ Female ☐ Other ☐

***Address**: ______________________ CAS/FACS involvement ☐

City: ______________ **Postal Code**: __________ Interpreter ☐__________ (language)

Patient Telephone: ______________________ Family Physician: ______________________

E-mail: ______________________

REFERRING DOCTOR: ______________________ FAX: ______________________

Address: ______________________ E-mail: ______________________

City: ______________ Postal Code: __________ Telephone: ______________________

DIAGNOSIS / REASON FOR REFERRAL: ______________________ See Attached ☐

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FOR RECEIVING OPHTHALMOLOGY TRIAGE

Accepted: ☐ Declined: ☐ Reason for decline: ______________________

Ophthalmology physician Notes: ________WKS ________MNTHS ☐ N/A ☐ ORTHOPTICS

Referral Type: ☐ General ☐ Cataract ☐ Neuro ☐ NLDO ☐ Strabismus ☐ ROP ☐ JA

Sub-Specialty: ☐ Glaucoma ☐ Oculoplastic ☐ Retina

Date Received: ______________________ U#M: ______________________