

RETINOPATHY OF PREMATURITY (ROP)

	PREMATURITY (ROP) REFERRAL	Address – Street	City	Postal Code
3V2 Ophthalmology Clinic 1200 Main St, West, Hamilton, ON L8N 3Z5		Telephone: () Cell Phone: ()	Ext.	
	e: 905-521-2100 Ext. 75300 (905) 521-2332	Date of Birth Age Gender M (yyyy/mm/dd)		
Refer	ral Date: (yyyy/mm/dd)	HIN	Family Physiciar	ı
REF	ERRING PHYSICIAN / PROVIDER INFORMATION:	CAS Worker In	nvolvement	
Printed Name		→ Name		
Signature and Designation		→ Contact Info		
Billing	g Number			
Refe	rring Hospital:			
Telep	phone: (ext) Fax:			
PATI	ENT LOCATION:	PATIENT INFOR	MATION:	
	Admitted ☐ Discharged Home → Discharge Date	Gestational Age:	(week	s)
(yyyy/mm/dd) Birth Weight: (grams)				s)
_	Transferred to another Hospital → Transfer Date (yyyy/mm/dd)	Corrected Age (a	t time of referral): _	(weeks)
Last	ROP Exam Date: (yyyy/mm/dd)	First Exam – Date Du	ie: (yyyy/mm/dd)	
Previ	ious Exam Follow Up Recommendations:	eek Two Weeks	Three Week	xs .
* PI	ease attach results of last ROP exam if available *			
Siani	ficant Past Medical History:			
- 13	,			
Interp	oreter Required: ☐ No ☐ Yes → Language			
FOR HHS USE	Date Received: (yyyy/mm/dd)	Date Triaged: (yyyy	//mm/dd)	
	Triaged By: Printed Name	Signature & Designation		
	Appointment Date: (yyyy/mm/dd)	Person Notified		

Patient's Last Name

First Name

