BENOE
LASER EYE CENTRE

CONSULTATION REQUEST FORM

All referrals are reviewed within 2-3 business days. A notification of the patient's appointment will be provided via fax. Form can be **Faxed:** 905-785-8384 OR **emailed:** referral@blec.ca

LOCATION: ☐ FIRST AVAILABLE OR ☐ SPECIFY _____

REFERRING DR.		BILLING NUMBER			
ADDRESS			EMAIL		
OFFICE PHONE		OFFICE FAX			

PATIENT DEMOGRAPHICS

PATIENT FIRST NAME			PATIENT LAST NAME		
PATIENT ADDRESS				CITY	
PATIENT EMAIL				POSTAL CODE	
PRIMARY PHONE				SEC PHONE	
HEALTH CARD #		VC		DOB (YYYY-MM-DD)	

PRE-PROCEDURE CLINICAL ASSESSMENT

UNAIDED VISUAL ACUITY	OD:	OS:
MANIFEST REFRACTION	OD:	OS:
CYCLOPLEGIC REFRACTION	OD:	OS:
KERATOMETRY	OD:	OS:
INTRAOCULAR PRESSURE (IOP)	OD:	OS:
PUPIL DIAMETER (DIM ILLUMINATION)	OD:	OS:
SLIT LAMP	OD:	OS:
FUNDUS	OD:	OS:

History of LASIK/PRK/SMILE YES ❑ NO ❑ Contact Lens Use: SCL ❑ RGP ❑ PMMA ❑

Counselling Provided: ASTIGMATISM CORRECTION ❑ LASER BIOMETRY ❑ PRESBYOPIA IOL OPTIONS ❑

Medical History (please list any active medical conditions, previous eye surgeries, diseases or injuries and any allergic reactions):

Accessibility needs or any additional comments: