

P (416) 929-2020

F (416) 929-0232

Patient Name: _____ Date of Birth: _____
(MM / DD / YYYY) Age

Address: _____

Phone Number: Home () _____ Work () _____

Cell () _____ Health Card # _____ Version Code _____

Email Address: _____

(Please complete all requested information)

History / Comments: _____

Date of Examination: _____ (MM/DD/YYYY)

Present Correction OD: _____ X _____ 20/ IOP: _____ Dominant Eye: _____
OS: _____ X _____ 20/ OD _____ OS _____ OD _____ OS _____

Slit lamp exam:
OD _____ OS _____

Fundus exam:
OD _____ OS _____

Discussed:
Advanced Technology Package: YES NO

Aspheric IOL :

Toric IOL :

Multifocal IOL :

Patient interested in:
Advanced Technology Package: YES NO

Aspheric IOL :

Toric IOL :

Multifocal IOL :

Referring Doctor / Optometrist: _____

Referring Number: _____

Address: _____

Phone #: _____ Fax #: _____

Email address: _____

Meeting Date: _____

Tx Date: _____

Comments: _____