eyecademy.ca
OPTOMETRY & EYE CARE
DR. STEPHANIE RAMDASS

SPECIALTY REFERRAL

Dry eye | Myopia management | Corneal care | Specialty lenses

FAX 905-823-6666

Quick-fill PDF: type the details, select the referral reason and fax.

PATIENT

Full name

Date of birth (YYYY-MM-DD)

Phone

REFERRING CLINIC

Optometrist / clinician

Practice name

Office phone

Return fax

REASON FOR REFERRAL

Select all that apply

- ☐ Dry eye / ocular surface
- ☐ Scleral / specialty lenses
- ☐ Corneal condition
- ☐ Lens intolerance / fitting
- ☐ Other specialty assessment
- ☐ Myopia management

CLINICAL QUESTION / REASON FOR CONSULTATION

Eye: ☐ OD ☐ OS ☐ OU

Brief notes are enough. Attach existing examination records rather than retyping them.

RECORDS ATTACHED (OPTIONAL)

- ☐ Exam notes
- ☐ Prescription
- ☐ Topography / imaging

☐ Patient is aware of the referral

Referral date

READY TO SEND

Fax the completed form and relevant records to:

905-823-6666

No routine phone call needed.

Urgent clinical question? Call 905-823-9999.

Verify the fax recipient before sending. Do not send records to the general email inbox.