

PLEASE CIRCLE:  
PHYSICIAN OR  
NO PREFERENCE

Dr. Theodore  
Rabinovitch

**URGENCY:**  Same Day  ASAP  Routine  Follow Up

Cataract Surgery & Refractive  
Lask PRK

PLEASE INFORM PATIENT TO BRING CURRENT LIST OF MEDICATIONS, EYE DROPS & RX GLASSES  
PLEASE ADVISE PATIENT OF TWO POSSIBLE APPOINTMENTS (PRELIMINARY TESTING & DOCTOR EXAMINATION)

Dr. Walid Abdelghaffar  
Retina & Cataract

Last Name:		First Name:	
Male/Female:	DOB (Y/M/D):	Cell #:	Home #:
Address:		Email:	
OHIP #:	Version Code:	Alternate contact:	

Dr. Seymour  
Hershenfeld  
Comprehensive

Reminder Preference:  Email  Text  Voice call

Dr. Tiiu Hess  
Oculoplastics  
Cataract Surgery

Referring Doctor:  Dr. OHIP Billing #:

Dr. Tran Le  
Cataract Surgery  
Paediatric

Address: Postal Code:  
Email: Fax: Tel:

Dr. Vlad Diaconita  
Medical Retina

<b>GLAUCOMA</b>	<input type="checkbox"/> High IOP	<b>REFRACTIVE SURGERY</b>	<input type="checkbox"/> Lasik/PRK Consult	<b>CATARACTS</b>	<input type="checkbox"/> OHIP Based Surgery
	<input type="checkbox"/> Disc Cupping		<input type="checkbox"/> Refractive Lens Exchange		<input type="checkbox"/> Premium IOL Selection
<b>RETINA</b>	<input type="checkbox"/> VF Field Loss	<b>CORNEA</b>	<input type="checkbox"/> Keratoconus/CXL	<b>OCULOPLASTICS</b>	<input type="checkbox"/> Refractive Cataract Surgery
	<input type="checkbox"/> Narrow Angles		<input type="checkbox"/> KScar / Edema / Other		<input type="checkbox"/> PCO
<b>GLAUCOMA</b>	<input type="checkbox"/> AMD DRY WET	<b>INFLAMMATORY DISEASE</b>	<input type="checkbox"/> Corneal Ulcer	<b>BOTOX</b>	<input type="checkbox"/> Chalazion/Lesion/Cyst/Lump
	<input type="checkbox"/> Hole/Tear/Detachment		<input type="checkbox"/> Pterygium		<input type="checkbox"/> Blepharoplasty Upper Lower Both
<b>RETINA</b>	<input type="checkbox"/> PVD/Floaters	<b>TESTING</b>	<input type="checkbox"/> Red Eye	<b>NEURO</b>	<input type="checkbox"/> Tearing
	<input type="checkbox"/> Retinal Lesion		<input type="checkbox"/> Episcleritis/Scleritis		<input type="checkbox"/> Entropion/Ectropion/Ptosis
<b>RETINA</b>	<input type="checkbox"/> Diabetic Retinopathy	<b>TESTING</b>	<input type="checkbox"/> Uveitis/Iritis	<b>DRY EYE</b>	<input type="checkbox"/> Blepharospasm
	<input type="checkbox"/> Macular Edema		<input type="checkbox"/> Visual Field/OCT/OPTOS		<input type="checkbox"/> Cosmetic/Fillers
<b>RETINA</b>	<input type="checkbox"/> Vein Occlusion	<b>TESTING</b>	<input type="checkbox"/> MTO	<b>DRY EYE</b>	<input type="checkbox"/> Optic Nerve (Drusen, Pallor)
	<input type="checkbox"/> Choroidal Nevus		<input type="checkbox"/> Pentacam Topography		<input type="checkbox"/> Diplopia
<b>RETINA</b>	<input type="checkbox"/> ERM	<b>TESTING</b>	<input type="checkbox"/> _____	<b>DRY EYE</b>	<input type="checkbox"/> Cranial Nerve Palsy
	<input type="checkbox"/> _____		OD OS OU		<input type="checkbox"/> Thyroid Abnormalities

Dr. Tom Klein  
Glaucoma  
Cataract Surgery

Dr. Jon Waisberg  
Dry Eye Disease

Cosmetic Botox

Dr. Farrah Moti  
General

Cataract Surgery

Dr. David E. Lederer  
Medical Retina

Dr. Yelin Yang  
Cataract Surgery

Specialty OD's

Dr. Sera Kwon  
Dry Eye Disease

Cataract Care

Dr. Ken Wan  
Glaucoma

No Preference

First Available

	OD	OS
BCVA		
REFRACTION		
IOP		

Additional Information:

\*Are you currently managing your patients' dry eye? YES or NO

PLEASE CIRCLE: LOCATION PREFERENCE

2065 Finch Ave. Suite 400  
Downsview, Ontario M3N 2V7  
Tel: (416) 748-2020  
Fax: (416) 7488582

2 Champagne Drive, Unit C2  
Toronto, Ontario M3J 2C5  
Tel: (416) 792-3043  
Fax: (416) 792-8705

7 Elmwood Ave.  
Toronto, ON M2N 6R6  
Tel: (647) 351-4393  
Fax: (416) 748-8582