GALEN EYE CENTRE

REFERRAL FORM

Galen Eye Centre
27 Place d`Armes, Suite 100,
Kingston ON K7K 6Z6
T: 613-507-4800 **F:** 613-507-4801

PATIENT INFO *(OR AFFIX LABEL)*

First Name: _____ Last Name: _____

Phone Number: _____ Date of Birth (mm-dd-yyyy): _____

Street Address: _____ Province: _____ Postal Code: _____

OHIP no.: _____ VC: _____

URGENCY

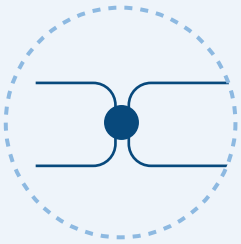
☐ **Urgent** (<24 hr) ☐ **Semi-Urgent** (<1 week) ☐ **Elective**

VISION

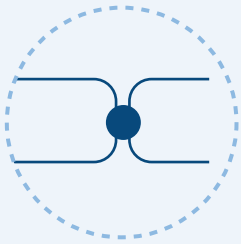
20 / _____ ☐ SC ☐ CC

IOP: _____

☐ **Right Eye**



☐ **Left Eye**



REFERRING DOCTOR INFO

Reason for Referral

Referring Doctor Name: _____ Telephone: _____

Billing #: _____ Fax: _____

Signature: _____ **Date:** _____

Please fax completed form to 613-507-4801 or email to wecare@galeneye.com