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NEUROLOGY CLINIC REFERRAL
NEURO-OPHTHALMOLOGY

FAX to JPOCSC Central Intake (604-953-9701)

PATIENT INFORMATION:

Patient's Name: ______________________________ **Gender:** ________
Last First Middle

Date of Birth: ______/______/__________ (DD/MM/YYYY) **PHN:** ______________ **Insurance:** ________

Address: ____
Street City Province Postal Code

Contact Method Primary: ________________ **Alternate:** ________________

REFERRAL INFORMATION:

Priority: ☐ Routine ☐ Urgent

Referring Health Care Provider:
Name: ________________
Title: ____________ **Source:** ____________
MSP #: ________________
Phone: ____________ **Fax:** ____________

Reason for Referral: ____

Medical Reason for Urgency: ____

Relevant Medical History: ____

Isolation precautions ☐ Airborne ☐ Contact ☐ Droplet ☐ None

Interpreter Required ☐ No ☐ Yes **If yes, specify language** ________________

Referral Clinic: Neuro-Ophthalmology

Referring Health Care Provider Signature: ________________ **Date:** ____________

Has this patient been seen by a neurologist previously? ☐ Yes ☐ No **(if Yes, please attach consult)**
Neurologist seen: ________________

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NEUROLOGY CLINIC REFERRAL
NEURO-OPHTHALMOLOGY Cont'd

FAX to JPOCSC Central Intake (604-953-9701)

PATIENT INFORMATION:

Patient's Name: ______________________ **Gender:** ________
Last First Middle

Date of Birth: ______/______/__________ **PHN:** ______________ **Insurance:** ________
(DD/MM/YYYY)

Address: ____
Street City Province Postal Code

Contact Method Primary: ________________ **Alternate:** ________________

ADDITIONAL CLINICAL INFORMATION:

☐ Consultation with specialist

Visual Field:	**Retinal Photography:**
☐ Octopus Automated Perimetry 30-2 ☐ Octopus Automated Perimetry 10-2 ☐ Octopus (Goldmann) Binocular Driving Field ☐ Octopus (Goldmann) Kinetic Perimetry	☐ Non-Mydriatic Fundus Photography (Dilation may be required) ☐ Composite Wide Angle ☐ Optic Disc (Stereo)

Oct:	**Retina:**	**Electrodiagnostics:**	
☐ Optic Nerve Head ☐ RNFL	☐ Dense Lesion ☐ Dense Macula ☐ Posterior	☐ Full Field ERG ☐ Pattern VEP	☐ Multifocal ERG ☐ Multifocal VEP

PATIENT PROFILE:

Visual Acuity	Pupil Size
Right Eye: ________ Left Eye: ________	Right Eye: ________ Left Eye: ________

Permission to Dilate Pupils and Topical Anesthesia:

☐ Permission to Dilate with Proparacaine 0.5%

☐ Permission to Dilate with Tropicamide 1 %

(Required for MFVEP, ERG. May not be required for Photography, OCT, Visual Field testing.

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