



**Diabetes Education Center
OTN Retinal Screening Program**

Etobicoke General Hospital
Diabetes Education Centre
Medical Office Building
89 Humber College Blvd. #224
TEL: 416-747-3400 Ext 33293
Fax: 416-747-3440

**Diabetes Education Center
OTN Retinal Screening Program**

Brampton Civic Hospital
Centre for Complex Diabetes Care
302-2250 Bovaird Drive East
BRAMPTON, ON L6R 3J7
TEL: 905-494-2260
FAX: 905-595-2863

Ophthalmology Retinal Screening Request

DATE OF REFERRAL: ____ / ____ / ____ (dd/mm/yy)

Location **BCH** **EGH** **(Please circle the preference)**

PATIENT INFORMATION

Last Name _____ First Name _____ Gender: M F

Health Card No. _____ Date of Birth ____ / ____ / ____ (dd/mm/yy)

Address _____

_____ Postal Code _____

Phone (____) _____ Alternate Phone (____) _____

Language if unable to speak English: _____

REFERRING PHYSICIAN INFORMATION

Name _____

Address _____

Phone (____) _____ Fax _____

OHIP Billing No. _____

REFERRING PHYSICIAN'S SIGNATURE _____

Family Physician Information (if different)

Name _____ Phone: (____) _____

PREVIOUS RETINAL EYE EXAM AND DIABETES INFORMATION

Years Diabetic: _____

A1C: _____

Insulin: Yes No

Previous Eye Exam; Date: _____ (dd/mm/yy)

RELEVANT MEDICAL HX MEDICATIONS & ALLERGIES (list or attach cumulative patient profile)

See attached, or: