Family Eye Care

Knowledge of past and present family eye disease can help you save your vision. Certain eye diseases, such as glaucoma and are-related macular degeneration (AMD), run in families while there symptoms progress so gradually that they go unnoticed. If you have a family history of eye disease, please use our self-referral form to book an appointment with our specialists.

There are many reasons why we all need to see an eye specialist on a regular basis:

- Many systemic diseases can affect the eye
- Some conditions of the eye are silent in nature and do not present signs or symptoms until a later stage
- Many hereditary eye diseases progress without any warning signs at all
- You may not be aware of some changes to your eyes that if properly assessed at an early stage, may prevent potential long term damage
- If age-related macular degeneration is in your family history, you may have up to 50% chance of developing the disease
- In adults, glaucoma and age-related macular degeneration are two leading causes of blindness which appear to be inherited
- Nearly two-thirds of people affected by vision loss are female
- Elderly individuals of African ancestry are five times more likely to develop glaucoma

You can also use our self-referral form to book an appointment with us if you:

- have a family history of eye disease such as Glaucoma and Age-Related Macular Degeneration
- Have a family history of diabetes
- Have used Steroids, Amiodarone, Plaquenil or Chloroquine
- Have a history of Systemic Lupus Erythematosus
- have eye glass prescriptions greater than 4D of power in either eye
- Are greater than 65 years of age
- Are experiencing decreased night vision
- Are experiencing eye lid abnormalities such as lid bumps and discolourations

OPHTHALMIC CONSULTANT CENTRES INC.
CANADIAN CENTRE FOR ADVANCED EYE THERAPEUTICS INC.

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VS. Q2 2012

FAMILY EYE CARE & SELF REFERRAL FORM

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Patient Self-Referral Form

Thank you for requestion an appointment with one of our specialists. All referrals will be examined withing 2 working days of our receiving this form. Please note that completion of this form does not guarantee an appointment as requested. If you have not been notified of an appointment date within one week, please contact our office. Please ensure all fields are completed below including patient name and a daytime phone number. Incomplete forms will not be processed. Faxing of this form is recommended.

Patient Name: _____ Phone #: _____

Patient Address: _____ City: _____ Postal Code: _____

DOB (mm/dd/yyyy): _____ OHIP#: _____ Version Code: _____

Check if requesting a specific doctor (optional)

☐ Dr. F. Ali ☐ Dr. N. Armogan ☐ Dr. N. Gill ☐ Any Available
☐ Dr. D. Yan ☐ Dr. D. DeAngelis ☐ Dr. A. Kosaric

Reason for referral:

☐ Glaucoma or Cataract
☐ Family History of Glaucoma
☐ High Cholesterol or Blood Pressure
☐ Family History of Macular Degeneration
☐ Other: _____
☐ Eyelid Problems
☐ Watery Eyes
☐ Macular Degeneration
☐ Diabetes
☐ LASIK

Please indicate if you have any of the following medical conditions:

☐ Diabetes ☐ Kidney Problems ☐ Heart Disease
☐ Thyroid Disease ☐ Cholesterol ☐ Blood Related Diseases
☐ High Blood Pressure ☐ Asthma ☐ Rheumatic Disease

Please list your current medications:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list current Doctor's name, phone and fax number:

Dr. _____ Phone: _____ Fax: _____

Dr. _____ Phone: _____ Fax: _____

For Office Use Only

Doctor Approved: ☐ Yes ☐ No
Time Line: ☐ Week ☐ Month ☐ AM ☐ PM

Age Appropriate: ☐ Yes ☐ No
Existing OCC Patient: ☐ Yes ☐ No

Patient to obtain records from: ☐ Optometrist ☐ Other Doctor(s): _____

Doctor Signature: _____ Date: _____

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