AM EYES
Ophthalmology Clinic

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Toronto Location
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Markham Location
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PATIENT REFERRAL FORM

Referring Doctor: ☐ Physician ☐ Optometrist **Urgency:** ☐ Urgent ☐ Non-Urgent

TORONTO OFFICE	☐ No Preference	☐ Dr. Kim Le	☐ Dr. Silvia Odorcic
MARKHAM OFFICE	☐ No Preference	☐ Dr. Silvia Odorcic	☐ Dr. Anita Ng

☐ Routine Exam	☐ Diabetic Check	☐ Cataracts	☐ Glaucoma
☐ Decreased Visual Acuity	☐ Conjunctivitis	☐ Dry Eye	☐ Diplopia
☐ Visual Field Issue	☐ Eyelid Problems	☐ Chalazion and Stye	
☐ Retinal Problem	☐ Corneal Problem	☐ Other: _____	

Details:

Referring Doctor: _____ Doctor Billing Number: _____

Office Phone _____ Office Fax: _____

Option #1: Affix Patient Label Here [ ]

Option #2: Fill Patient Information Below:

☐ Male ☐ Female ☐ Other

Full Name: _____

DOB (DD/MM/YY) _____ OHIP Number: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Phone: _____ Email: _____

Please fax to (416) 925-1335 or Email clinic@ameyes.ca