ADVANCED VISION CENTRE

PATIENT DIAGNOSTIC REQUEST

REFERRING DOCTOR INFORMATION

Name: _____
Practice Name: _____
Doctor/office phone:_____
Doctor/office fax: _____
Doctor/office email: _____

PATIENT INFORMATION

First Name:_____
Last Name: _____
DOB: (DD/MM/YYYY)_____
Patient e-mail: _____
Patient phone: _____
Health Card #: _____ Version Code:_____
Expiry Date: (DD/MM/YYYY)_____
Diagnosis code patient is coded under:_____

REASON FOR REFERRAL

	OD	OS	OU
Retinal Photography	☐	☐	☐
Visual Fields			
24-2	☐	☐	☐
120 Point	☐	☐	☐
10-2	☐	☐	☐
Esterman(MTO)	☐	☐	☐
OCT Incudes Macular Cube HD Cross, GCA, Optic Disc	☐	☐	☐
YAG Laser	☐	☐	☐

BILLING:

To Optometry Office ☐ To Patient ☐

PLEASE **FAX TO: (519) 873-1691 OR**
EMAIL: vision@lo.advancedmedicalgroup.ca

230 Victoria Street, London, ON N6A 2C2
Phone: (519)873-1611
www.Advanced MedicalGroup.ca