Diabetes Retinopathy Screening
REFERRAL FORM
Fax: 613-774-7235 | Toll free fax: 1-833-384-9993
Inquiries: (613) 233-4443 ext. 2169 | deso@centretownchc.org

Patient information

Referral date	Patient first name	Patient last name

Date of birth (YYYY/MM/DD)	Preferred language ☐ Interpretation required	Phone number

Address	Postal code

Health plan: ☐ OHIP ☐ IFHP ☐ No insurance ☐ Other (specify):

Health card # / insurance ID	Version code

Gender: ☐ Woman ☐ Man ☐ Non-Binary ☐ Two-Spirit ☐ Questioning/Unsure ☐ Gender fluid or gender queer ☐ Do not know ☐ Prefer not to answer ☐ Another gender identity (specify):

Diabetes and clinical information

Diabetes: ☐ Type 1 ☐ Type 2 ☐ Prediabetes ☐ Other (specify):

Years since diagnosis	Insulin use: ☐ Yes ☐ No	HbA1c (%)	Date (YYYY/MM/DD)
____ years			

Blood pressure (mmHg)	Date (YYYY/MM/DD)	LDL (mmol/L)	Date (YYYY/MM/DD)
Systolic: Diastolic:			

Complications / co-morbidities (if available)
☐ Cardiovascular disease ☐ Kidney disease ☐ Hypertension ☐ Neuropathy ☐ Nephropathy ☐ Dyslipidemia ☐ Other (specify):

Diabetes medications	Other (specify)

Eye health information

Known ocular diseases (if available)
☐ Cataract ☐ Glaucoma ☐ Age related macular degeneration ☐ Other (specify):

Ever had an eye exam for retinopathy?	Date of last dilated eye examination (YYYY/MM/DD)
☐ Yes ☐ No ☐ Not known	☐ Date not known

Optometrist / ophthalmologist name (if available)

Referring provider information

☐ Please check here if you would like us to arrange follow-up with a retina specialist or ophthalmologist if screening detects retinopathy requiring specialist care.

Referring physician / nurse practitioner - Name

Signature	Billing number

Referring provider - Phone number	Referring provider - Fax number

Diabetes educator name (if applicable)