CHOW EYE INSTITUTE

398 Ferrier Street, Unit 101
Markham, Ontario, L3R2Z5
905-415-3881; Fax: 416-443-9222
choweye2020@gmail.com

Dr. Edward S. Chow OD **Dr. Jeffrey S. Ng** OD **Dr. Theodore R. Chow** OD, MSc

Referring Doctor

Name:

Clinic Name:

Phone:

Fax:

Email:

Specialty: OD / MD / Other

Patient Information

Name:

DOB:

Phone:

Email:

Referral Reason	
Orthokeratology	
Myopia Control	
Scleral Contact Lenses	
Keratoconus Management	
Corneal Transplant Care	
Multifocal Contact Lenses	
Dry Eye Syndrome Management	
Meibography	
Topography	
Vision Therapy	
Other:	

Patient Care

☐ I would like to refer this patient for complete transfer of care.

☐ I would like to continue comprehensive care, please co-manage specialty care only.

Clinical Assessment/Diagnosis

**Please attach any exam notes/topography where applicable.

We will call your patient to schedule an evaluation/contact lens fitting with one of our doctors within 1-3 business days of receiving your referral. You will receive an email/fax with progress notes on our evaluation and plan when you patient has been seen. Please send completed form to our office fax and/or email (above).