



# Animal Eye Clinic of Waterloo Region

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## Ophthalmology Referral Form – Please Fax to 519-658-5060

<p><i>Please note that due to some clients not showing up for their appointment, we now require prepayment in full at the time of booking for the initial consultation and diagnostic tests. Please notify your clients of this prior to referral.</i></p>											
<p>If the patient has already been seen by another Ophthalmologist, please call our clinic prior to sending the referral.</p>											
Last name:			Home Ph:								
First name:			Cell Ph:								
Address:			E-mail:								
City:			Postal code:								
Pet's name:			Sex:			F	FS	M	MN		
Breed:			Age:			Years				Months	
Weight:			Kg	Colour:							
Clinic			Referring DVM								
Clinic Ph:			Clinic Fax:								
Clinic E-mail:			Urgency:			As soon as possible		Next available			
1.	Which eye(s) have the problem?				2.	How long have the change(s) been present?					
	Right	Left	Both			Days	Weeks	Months			
3.	Your clinical findings?				Diagnostic Tests	Schirmer Tear Test	Fluorescein Stain	IOP (circle instrument used) Tonopen, Tonovet, Schiotz			
R					Right						
L					Left						
4.	Your treatments/medications for this condition.										
5.	Any improvement on these medications?			Y	N	6.	Any other health conditions and/or medications?				
	If so, which ones?										
AEC Office Use:	1	2	3	4	Appointment	Date		Time			
Date:											
Date:											
Date:											