envision
EYE INSTITUTE

☐ **Dr. Minoo Azadeh** ☐ **Dr. Nataly Pesin**

Patient: _____ Male: ____ Female: _____ Other: _____
Surname First Name

Telephone: _____ Cell: _____ Email: _____

Address: _____ Unit #: _____

City: _____ Postal Code: _____

DOB: _____ Health Card #: _____ Version Code: _____
DD / MM / YY

Referring Doctor: _____ Provider #: _____

Referring Office Contact Info:

Tel: _____ Fax: _____

Office Email: _____ Family Doctor: _____

Reason for Referral:

Anterior Segment		**Glaucoma**	**Retina**	
☐ Cataracts	☐ PCO	☐ High IOP	☐ Flashes & Floaters	☐ Macular Disease
☐ Pterygium		☐ Cupping	☐ Diabetic Check	☐ ERM
☐ Uveitis/Iritis		☐ Narrow Angles	☐ AMD	

Cornea: _____

Lid Lesions: _____ Other: _____

Additional Information: _____

	Right Eye	Left Eye
Refraction		
Best Corrected Vision		
IOP & Method		
CCT		

Envision Office use Below ----------

Pre-testing appointment has been scheduled on: _____ at _____ AM / PM

Consultation with Dr. _____ has been scheduled on _____ at _____ AM / PM

Patients need to be informed of the office visit wait times of 90-120 minutes and the eye drops may cause light sensitivity and blurry vision. Sunglasses and a driver are recommended if pupils need to be dilated.