MINDS
Mississauga Institute of Neurological Disorders and Stroke

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REQUISITION FORM FOR NEURO-OPHTHALMOLOGY CONSULTATION

PATIENT INFORMATION

Last Name:	First Name:	Gender: □ Male □ Female
Date of Birth (DD/MM/YYYY):	Home #:	Cell #:
Health Card #:		
□ OHIP □ Private Pay □ Motor Vehicle Accident	□ Emergent □ Urgent □ Non-Urgent	

PAST MEDICAL HISTORY

INDICATION(S) FOR CONSULT

□ Acute vision loss	□ Diplopia
□ Transient vision loss	□ Cranial nerve palsy
□ Optic neuritis	□ Stroke/Amurosis
□ Optic neuropathy	□ Suspected papilledema
□ Giant cell arteritis	□ Pupillary abnormalities
□ Idiopathic intracranial hypertension (IIH)	□ Others:

NEURO-OPHTHALMOLOGY INVESTIGATION(S)

□ Consult + Investigation(s)	□ Visual field
□ Investigation(s) only	□ Fundus photography
	□ OCT (ganglion cell layer and RNFL)

REFERRING PHYSICIAN INFORMATION

Name:	Billing Number:
Phone:	Fax:
Copies to:	