Animal Eye Clinic
of Waterloo Region

405 Maple Grove Road, Unit 14
Cambridge, Ontario N3E 1B6
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Fax: 519.658.5060
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www.myeyevet.ca

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

Last name:		**Home phone:**				
First name:		**Work phone:**				
Address:		**Cell:**				
City:		**Postal code:**				
Pet's name:		**Sex:**	F	FS	M	MN
Breed:		**Colour:**				
Age or birth date:						
Referring DVM:		**Clinic:**				
Alternate DVM:		**Clinic:**				
1. Which eye(s) have the problem?		Right	Left	Both		
2. How long have the change(s) been present?						
3. Your clinical findings?						
4. Your treatments for this condition. Can you also please list the medications dispensed.						
5. Any improvement on these medications?		Yes	No			
If so, which ones? Please list.						
6. Any other health conditions and/or medications?						
7. Do you need more referral forms		Yes	No			