GUPTA EYE CENTRE

Dr. Daya K. Gupta
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CONSULTATION SHEET

PATIENT'S INFORMATION:

Appointment Date: ____

Name: ____________________________________ **DOB:** m_____ d ______ yr _______

Address: __________________________________ **Phone Numbers:** H __________________

W__________________

MHSC # ____________________________

PHIN # _____________________________

CHIEF COMPLAINTS:

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____
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Cataract Evaluation & Surgery ______

Glaucoma Assessment & Management ______

Retinal Problem ______

Others ______

EXAMINATION:

Visual Acuity (without correction) R _____ L _____ **IOP** R ____ L ____

Visual Acuity (with correction) R _____ L _____
Refraction & Prescription of Glasses (if available)

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____

Ocular Findings:

____
____

REASON FOR CONSULTATION:

Urgent ____ Semi-Urgent _____ Regular Appointment _____

We will try to accommodate your request soon. BEFORE E-MAILING OR FAXING THIS FORM, PLEASE CALL OUR OFFICE TO BOOK THE APPOINTMENT.

Dr. D. K. Gupta
Eye Surgeon