Robert Schertzer, MEd, MD, FRCSC

Ophthalmology Consult Request

MSP# 26035

Dr. Robert Schertzer Inc.
westcoastglaucoma.com
info@iguy.org

Date of Referral: _____

Patient Name: _____

PHN: _____ DOB: _____
YYYY / MM / DD

Patient Phone: _____

Patient Email: _____

Referred by: _____ Billing #:_____

Address: _____

Phone: _____ Fax: _____

Email: _____

New or repeat consult (check ONE ONLY):

☐ New consult ☐ Repeat consult (same condition) ☐ Repeat consult (new condition)

Reason for referral (check all that apply):

☐ Glaucoma ☐ Diabetes ☐ Cataracts ☐ Flashes/Floaters ☐ Red eye

☐ Pain ☐ Decreased vision ☐ Other _____

To make an appointment, use the online form or fax this COMPLETED form to:

NEW as of Feb 1, 2024

FAX: (604) 876-6557

Dr. Robert Schertzer Inc.
943 W. Broadway, Suite 950
Vancouver, BC V5Z 4E7
Ph: (604) 876-7433

We triage requests throughout the day; calling does not get your patient in more quickly unless it's a true emergency.

We will fax the appt. information to you. Patients will receive up to 3 appointments: a consult, visual field testing, and imaging, depending on the diagnosis.

Please tell patients that the appt can take up to 2 hours. They should bring their preferred glasses and ALL medications, including eye drops.

The waiting room size is limited; please ask patients to bring no more than one support person to the visit.

Vision and Refraction

V_{cc} (far): OD 20 / _____ OS 20 / _____

MRx: OD _____

OS _____

Date / Time		
IOP OD ☐ A ☐ NCT	mm Hg	mm Hg
IOP OS ☐ A ☐ NCT	mm Hg	mm Hg
c/d OD		
c/d OS		

Additional Clinical Notes
(history, meds, surgeries, questions)