Dry Eye Referral Form

Referral hotline: 289-348-1771

DR. PATRICIA FINK & ASSOCIATES
Main office: 905-319-1066
Fax: 289-205-1466
visiontherapy@drfink.ca
www.drfink.ca

Patient Information

Name _____

Date Of Birth _____ Gender ◯ Male ◯ Female ◯ Other

Phone Number _____ Email _____

Address _____

_____

Preferred Provider _____

Referring Practitioner Information

Name _____

Phone Number _____ Email _____

Address _____

_____

Additional Information

Please provide any additional information or special requests below.

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