SOUTHLAKE
REGIONAL HEALTH CENTRE

581 Davis Drive
Newmarket, Ontario
L3Y 2P6

Tel. (905) 895-4521
Fax. (905) 830-5972
southlake.ca

CATARACT CENTRE / EYE INSTITUTE

581 Davis Drive, Newmarket ON, L3Y 2P6 – Level 4

Medical Arts Building (across the street from the main hospital building)

Please read both sides of this envelope. Bring this envelope and all the papers inside to all appointments and to the hospital on the day of your procedure.

Your surgery will be cancelled if you do not have an escort stay with you while you are having your procedure, drive you home and stay with you for the rest of the day and overnight.

Patient Name: *(print first, last)*	**Date of Surgery:** dd/mm/yy *(Level 4, Medical Arts Building)*
Surgeon Name: *(print first, last)*	**Time to Arrive:** _____

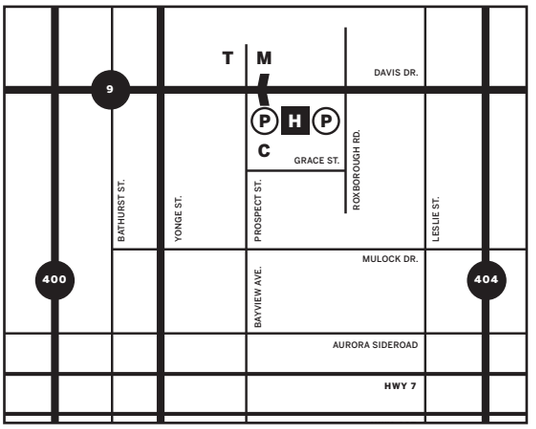
1. **COMPLETE** the Pre-Assessment Patient Questionnaire enclosed.
2. **ALWAYS BRING:**
   - This envelope and ALL the papers inside.
   - Your valid Ontario Health Card.
   - All or a list of medications that you are presently taking including herbal remedies and medications available without a prescription. Please include dosage and times taken per day.
   - Medications that you may need such as puffers, nitroglycerin, insulin.
   - Debit/credit card if purchasing a premium lens
   - A Loonie ($1.00) for a wheelchair deposit fee
3. **FASTING GUIDELINES:**
   - **STOP EATING** solid food includes gum, candies and mints **8 hours before the admission time**
   - You are encouraged to drink water and/or apple juice up to 3 hours before your arrival.
   - **STOP DRINKING** 3 hours before your arrival time, not even water.
4. If you are **UNABLE TO HAVE YOUR SURGERY** on the date shown above, please call your surgeon's office **AS SOON AS POSSIBLE.**

PARKING:

Parking for the Medical Arts Building is available in the Parking Garage located at the corner of Prospect Street and Davis Drive.

Please bring change or a credit card for parking charges, which can be paid at the pay stations located in the Parking Garage or along the bridge.

- **M** Medical Arts Building, 581 Davis Drive
- **H** Southlake Regional Health Centre
- **C** Stronach Regional Cancer Centre
- **T** The Tannery Mall, 465 Davis Drive
- **P** Parking
- **(** Bridge crossing Davis Drive. Accessible from P3 of the Parking Garage and Level 3 of the Medical Arts Building.



SURGERY INSTRUCTIONS

The following instructions have been provided for your safety.
PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY to avoid having your surgery or procedure cancelled.

Before you come to the Hospital to have your surgery or procedure:

- Have ALL your tests done and attend all preoperative appointments that your surgeon has requested
- Ask your Doctor/Surgeon which of your medications you should take as usual the day of your surgery, or if there are any you should stop before your surgery.
- If your health changes in any way (a cold, if you become pregnant, or think you may be, etc.) after your appointment has been booked, please contact your Doctor/Surgeon/Specialist. Make sure the Admitting Nurse knows of any changes in your health when you arrive.
- Make sure you have someone accompany you that can:
    1. Stay with you during your surgery and drive you home.
    2. Speak English, if you cannot
    3. Legally sign a consent, if you cannot (bring Medical Power of Attorney legal documents, if necessary)

The night before your surgery:

- **STOP EATING** solid food includes gum, candies and mints **8 hours before the admission time**
- You are encouraged to drink water and/or apple juice up to 3 hours before your arrival.
- **STOP DRINKING** 3 hours before your arrival time, not even water.
- You may take your usual medications in the morning with a **SIP of water unless instructed not to by your Doctor**

The morning of your surgery or procedure:

- Take all your usual medications as instructed by your doctor with sips water. **Do not take diabetic pills or short acting insulin.** Your doctor will recommend changes if you take long action insulin. It is usual to take half the dose of long acting insulin.
- Take a shower or bath. Remove all make-up, nail polish and jewelry including body piercings. Wear comfortable clothing (not white). A button front shirt is preferred. Tie back long hair. Wear glasses rather than contact lenses. Wear your hearing aid.
- The hospital assumes no responsibility for patient valuables and personal belongings e.g., cell phones, electronic devices, cash, expensive clothing, purses, wallets etc.
- Bring all of the **ALWAYS BRING** items listed on the front of the envelope

THANK YOU FOR READING AND FOLLOWING OUR INSTRUCTIONS

Special Instructions:_____

_____

_____

SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #: _____ Complete or place barcoded patient label here

Patient Name: *(Print first, last)* _____

DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male

OHIP #: _____ Version Code: _____

Account #: _____ Date of Admission: dd / mm / yy

Consent to Treatment *- Please review and complete all applicable boxes.*

Verification of Consent Discussion

I, _____, authorize _____ and/or
(print first, last name of patient) *(proposer of treatment)*

other healthcare practitioners, physicians or hospital staff that he/she might designate to assist him/her, or to perform the following operation(s), test(s), treatment(s):

_____

_____on myself.

The proposer of treatment has explained to me the diagnosis, recommended treatment, expected benefits, related significant risks, alternative treatments (including the option to not treat), as well as significant risks associated with those options, in a manner that I have understood.

If the proposer of treatment discovers a different, unsuspected condition at the time of treatment, I authorize him/her to perform such operation(s), test(s) and treatment(s), which are thought to be essential for the maintenance of life or vital function, in addition to or in place of those authorized above.

The proposer of treatment has explained to me that anesthetics may be necessary and are to be administered by a person responsible for this service.

PATIENT'S STATEMENT

I acknowledge that:

- I have had a consent to treatment discussion with the proposer of treatment.
- I have had the opportunity to ask questions. The proposer of treatment has answered all my questions to my satisfaction.
- I understand I can withdraw this consent any time before the beginning of the operation(s), test(s) and treatment(s).

❑ Patient ***OR*** ❑ Substitute Decision Maker (SDM) in the case of an incapable patient

Name: *(print first, last)* _____ _____
(Relationship if signed by other than patient)

Signature:_____ **Date:** dd / mm / yy **Time:** _____

PROPOSER OF TREATMENT STATEMENT: (This box may be used by proposer of treatment for documentation purposes if the consent discussion has not been documented elsewhere.)

I have explained to _____ the diagnosis, recommended treatment, expected
(patient or substitute decision maker)

benefits, related significant risks, alternative treatments (including the option to not treat) and significant risks to the patient related to the operation(s), test(s), and treatment(s), written above.I have answered all questions raised by the patient to the best of my knowledge. I believe the patient has been adequately informed.

Name of Proposer of Treatment: *(print first, last)* _____ **Discipline:** _____

Signature: _____ **Date:** dd / mm / yy **Time:** _____

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REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #: _____ Complete or place barcoded patient label here

Patient Name: *(Print first, last)* _____

DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male

OHIP #: _____ Version Code: _____

Account #: _____ Date of Admission: dd / mm / yy

Consent to Treatment *- Please review and complete all applicable boxes.*

EMERGENCY TREATMENT WITHOUT CONSENT

I certify that, due to the urgent need for operation(s), test(s) and/or treatment(s), I am unable to obtain informed consent prior to the operation(s), test(s) and treatment(s). I have no knowledge of an advanced directive or other information indicating that receiving operation(s), test(s) and treatment(s) in these circumstances would be rejected by this patient. I have documented on the patient's health record the rationale for the operation(s), test(s), and treatment(s).

Name of Proposer of Treatment: *(print first, last)* _____ M.D.

Signature: _____ **Date:** dd / mm / yy **Time:** _____

TELEPHONE CONSENT FROM SUBSTITUTE DECISION MAKER:

I confirm that I have explained to _____ _____
(Substitute Decision Maker) *(Relationship to patient)*

the diagnosis, recommended treatment, expected benefits, related significant risks, alternative treatments (including the option to not treat) and significant risks to the patient. I have answered any questions by the substitute decision-maker to the best of my knowledge. I believe the substitute decision-maker has been adequately informed.

Name of Proposer of Treatment: *(print first, last)* _____ **Discipline:** _____

Signature: _____ **Date:** dd / mm / yy

Telephone Number: _____ **Time of Call:** _____

Other Healthcare Professional Witnessing Consent Discussion: *(print first, last)*

_____ **Discipline:** _____

Signature: _____ **Date:** dd / mm / yy **Time:** _____

IF ANY INTERPRETER IS USED TO COMPLETE ANY PART OF THIS FORM COMPLETE BELOW:

❑ Internal interpreter ❑ External Interpreter

Name of interpreter: *(print first, last)* _____

Name of Interpreter Service Utilized: _____

OUT OF COUNTRY RESIDENTS

Note: The Proposer of Treatment must ensure the "Governing Law and Jurisdiction of Medical Liability SL1316" has been signed and is on the Patient Health Record. This is available for printing via the Intranet at Governing Law & Jurisdiction form SL1316.

SL1271A_12 (05/23) "Southlake Regional Health Centre" Review (05/26)

SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Preoperative Patient Questionnaire (to be completed by patient and/or caregiver)

Name: *(print first, last)* **Date of Birth:** dd / mm / yy

Height: **inches or cm** *(please circle)* **Weight:** **lbs or kg** *(please circle)*

Operation/Surgery/Admission	When/Where	Operation/Surgery/Admission	When/Where

Anesthesia History *(please check all that apply)*

- ❑ No known problems with anesthesia
- ❑ Malignant Hyperthermia
- ❑ Pseudocholinesterase Deficiency
- ❑ Difficult Intubation
- ❑ Nausea and Vomiting
- ❑ Confusion After Surgery
- ❑ Family Member Reaction to Anesthetics
- ❑ Problems opening your mouth or moving your neck
- ❑ Caps/Crowns ❑ Dentures ❑ Bridge ❑ Implants ❑ Loose Teeth
- ❑ Neck/Jaw/Mouth Problems

Please list your medications, supplements and vitamins

Name of Drug / Herbal Product	Dose	Time of day	Name of Drug / Herbal Product	Dose	Time of day

Allergies and Reaction:

Heart Health (Cardiovascular) ❑ Normal

- ❑ High Blood Pressure
- ❑ Heart Attack ❑ Heart Bypass ❑ Stents
- ❑ Chest Pain (Angina)
- ❑ Irregular Heart Beat (A Fib., SVT, VT)
- ❑ Heart Failure
- ❑ Poor Circulation (PAD, PVD)
- ❑ Valve Problems ❑ Mechanical Valve
- ❑ Pacemaker/Implantable Defibrillator
- ❑ Other_____

Lungs / Breathing (Respiratory) ❑ Normal

- ❑ Asthma
- ❑ COPD ❑ Home Oxygen _____L/min
- ❑ Recent cold/flu
- ❑ Shortness of Breath Walking or Climbing Stairs
- ❑ Sleep Apnea/Severe Snoring ❑ CPAP Yes ❑ No ❑
- ❑ Tuberculosis
- ❑ Other_____

SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #: _____ Complete or place barcoded patient label here

Patient Name: *(Print first, last)* _____

DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male

OHIP #: _____ Version Code: _____

Account #: _____ Date of Admission: dd / mm / yy

Preoperative Patient Questionnaire *(to be completed by patient and/or caregiver)*

Gastrointestinal and Kidney Health ❑ Normal

- ❑ Heartburn/Acid Reflux
- ❑ Hiatus Hernia
- ❑ Ulcers
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Dialysis
- ❑ Other: Describe_____

Nerve, Muscle and Bone Health ❑ Normal

- ❑ Stroke/TIA ❑ Seizures
- ❑ Spinal Cord Problems ❑ Brain Aneurysm
- ❑ Parkinson's ❑ ALS ❑ Multiple Sclerosis
- ❑ Dementia ❑ Neuropathy ❑ Fibromyalgia
- ❑ Osteoarthritis ❑ Rheumatoid Arthritis
- ❑ Ankylosing Spondylitis ❑ Chronic Pain
- ❑ Anxiety ❑ Depression
- ❑ Other: Describe_____

Endocrine and Metabolic ❑ Normal

- ❑ Diabetes ❑ Type I ❑ Type 2
- ❑ Thyroid ❑ Low ❑ High
- ❑ Other_____

Blood Health ❑ Normal

- ❑ Diagnosed Blood Disorder ❑ Blood Clots (DVT/PE)
- ❑ Bruise Easily ❑ Anemia
- ❑ Sickle cell trait/disease ❑ AIDS/HIV ❑ Hepatitis

Do you have any antibiotic resistant organisms

MRSA, VRE, ESBL, CPE ❑ Yes ❑ No

Have you had cancer?

Describe:

Have you lost weight in the past 6 months without trying?

❑ Yes ❑ No

Have you been eating less than usual for more than a week? ❑ Yes ❑ No

Can you walk 2 blocks at a normal pace without stopping?

❑ Yes ❑ No

Are you able to lie flat for 15-30 minutes? ❑ Yes ❑ No

Other Important Medical Information

Do you smoke any of the following:

❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Vape ❑ Marijuana

Number per day _____

Do you use street drugs *(please list)*

Cannabis: ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How much_____

Any Other Health Concerns We Should Know About?

Have you ever had any of the following tests?

- ❑ Exercise Stress Test (Treadmill)
- ❑ Holter Rhythm Test
- ❑ Heart Echo (Ultrasound) Test
- ❑ Heart Catheterization (Angiogram)
- ❑ Nuclear Medicine Heart Scan Test
- ❑ Lung (Pulmonary) Function Test

In the past five years, have you been seen by one of these Medical Specialists

❑ Family Doctor	❑ Nerve Specialist (Neurologist)
Name:	Name:
❑ Heart Specialist (Cardiologist)	❑ Kidney Specialist (Nephrologist)
Name:	Name:
❑ Lung Specialist (Respirologist)	❑ Other
Name:	Name:

SL0468_10 (06/23) "Anesthesia" Review (06/26)

The Eye Institute at Southlake

PATIENT GUIDE TO CATARACT PROCEDURE

SOUTHLAKE
REGIONAL HEALTH CENTRE

Key Points

1. Do not eat anything after midnight the night before your procedure.
2. **Arrange to have someone accompany you to the procedure, drive you home and stay with you for the remainder of the day and overnight.**
3. Bring the large pre-operative envelope with all the paperwork completed.
4. Take all of the eye drops your doctor has prescribed.
5. Register at the Welcome Centre on Level 4 before coming to the Eye Centre.
6. Bring a debit or credit card, if purchasing a upgraded lens.
7. Bring a $1.00 coin for the wheelchair deposit.

Parking

Parking for the Medical Arts Building is available in the Parking Garage located at the corner of Prospect Street and Davis Drive.

The bridge linking the Parking Garage to the Medical Arts Building is accessible from level P3 of the Parking Garage.

Please bring cash or credit card for parking charges, which can be paid at the pay stations located in the Parking Garage and along the bridge.

The Eye Institute at Southlake

The Eye Institute at Southlake is a modern, state-of-the art facility, which offers a patient-centred model of care focused on excellent outcomes and ease of access.

The Eye Institute is located on the fourth floor of the Medical Arts Building, which is located directly across the street from the main Hospital. It combines a patient and family friendly environment, spacious assessment and treatment rooms, and a comfortable waiting room.

The Institute is firmly committed to improving access by significantly reducing wait times for patients who need treatment for various types of eye conditions and surgery. The Cataract Program is the first of many outstanding services to be offered at the Eye Institute at Southlake.

What is a Cataract

A cataract is a clouding of the lens inside the eye, which, over time, progresses to the stage where vision becomes blurred. Cataracts are common, and are most frequently related to aging. According to research by the Canadian National Institute for the Blind, about 50% of people between 55 and 64 years of age, and 85% of people over 75 years of age, will develop cataracts within the next 10 years.

Symptoms of a Cataract

Common symptoms of a cataract are:

- Clouded or blurry vision
- Faded appearance of colours
- Glare: headlights, lamps, or sunlight may appear too bright (a halo may appear around lights)
- Double vision or multiple images in one eye
- Frequent prescription changes in eyeglasses or contact lenses

The Cataract Procedure

A Cataract procedure is generally recommended when a cataract reduces vision to the point that a patient can no longer read or drive. At the Eye Institute at Southlake, the latest diagnostic equipment and techniques are used to replace the clouded lens with a new corrective lens. A standard lens is available at no cost to the patient. Other lenses are available for purchase. Discuss with your surgeon your lens options.

The procedure is performed with minimum discomfort and the patient will normally return home the same day. The pre and post procedure areas can accommodate one family member, friend or support person.

As patients will not be able to drive after surgery, a family member, friend, or an escort is required to accompany them to the procedure, and assist in getting them home safely.

The Cataract Program's Team members

The success of the Cataract Program relies heavily on highly experienced Royal College-certified ophthalmic surgeons, and a well-trained team of anesthesiologists, nurses, and support staff. These professionals are dedicated to using the most advanced technology to achieve the best possible outcomes, and providing the highest level of personalized care for our patients.

This booklet has been developed for you, your family, and friends. Please read the information carefully before you check in for your procedure. If you must cancel your surgery, please call the surgeon's office as soon as possible. We advise you to bring an interpreter if you cannot speak English.

Before the Day of Your Procedure	
Clinical Assessment	• Complete the Preoperative Patient Questionnaire found in the envelope yourself. • Attend a pre-admission appointment, if your surgeon recommends it.
Teaching/ Discharge Planning	• Read the "Patient Guide to Cataract Procedure." • Read all of the information on the preoperative envelope given to you by the ophthalmologist. • Arrange to have someone go the Eye Institute with you, drive you home and stay with you for 24 hours after your eye surgery.
Nutrition	• Continue with your regular diet.
Medications/ Treatments	• Take all of the drops that the ophthalmologist has ordered for you. See How To Administer Eye Drops on page 10. • Continue taking your regular medications, unless told otherwise by your surgeon. Bring a list of all your medications with you to all your preoperative appointments and to the Eye Institute on the day of your surgery.

Day of Surgery: Before Your Procedure	
Clinical Assessment	• A nurse will take your temperature, pulse, blood pressure and oxygen level and do a short health review. • Tell the nurse if your health has changed in any way since you last saw a doctor. • An Anesthesiologist and/or Anesthesia Assistant will ask you about your health and review your completed Preoperative Patient Questionnaire.
Teaching/ Discharge Planning	• Do not wear jewellery, contact lenses, make-up, or nail polish. • Ask any questions you may have. • Wear comfortable clothing and footwear. A buttoned shirt is preferred.
Nutrition	• DO NOT EAT AFTER MIDNIGHT; take clear fluids ONLY such as water, clear apple juice, jello, black coffee and/or tea. Do NOT have milk, cream, sugar or sweetener in coffee or tea after midnight the day of your surgery • Stop drinking two hours before your arrival time. • Do not chew gum, have candy or lozenges.
Activity/Safety	• You will be asked about your allergies. Please bring a list of your allergies and the type of reaction that occurs. • The staff will ask you which eye is being operated on, your name and your birthdate a few different times during the process.
Medications/ Treatments/ Procedures	• Take all of the eye drops that the ophthalmologist has ordered for you. • If you are diabetic, you may have your blood sugar tested. • Take all of your usual medications including blood thinners with sips of water unless told otherwise by your surgeon. DO NOT TAKE DIABETIC PILLS OR SHORT ACTING INSULIN. Your doctor will recommend changes to your long acting insulin. It is usual to take half the dose of a long acting insulin. • An IV will be started.

Day of Surgery: During Your Procedure	
Clinical Assessment	• You will be attached to a monitor and the Anesthesia Assistant will monitor you and give you sedation.
Teaching/ Discharge Planning	• If possible, do not move or cough during the procedure. • You will be asked your full name, birthdate, the operation and the site and about your allergies.
Activity/Safety	• The doctor will ask which eye is being operated on before the procedure starts.
Medications/ Treatments/ Procedures	• The area around your eye will be cleaned. • A cover will be placed to keep your eye clean. • A microscope will be positioned above your eye. • Please look straight at the bright microscope light and do not move during the procedure. • Equipment noises and procedure related conversation will be heard. • Pressure, touch and drops of "water" will be felt. • Let someone know if you experience pain during the procedure. • Before leaving the operating room, the surgeon will put a hard shield over your eye.

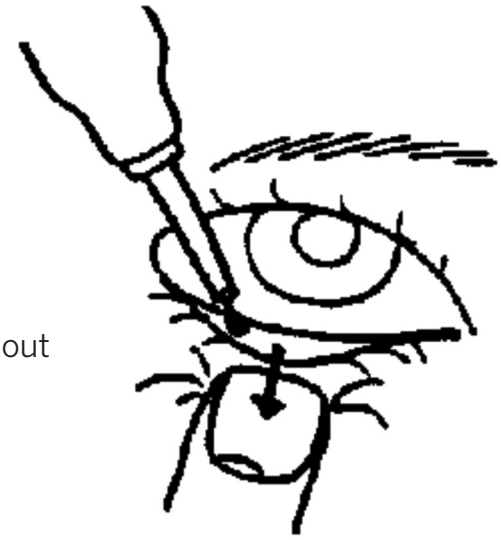
Day of Surgery: After Your Procedure	
Clinical Assessment	• Your pulse, and blood pressure will be taken following the procedure. • Before you leave, the nurse will confirm your follow-up appointment with the ophthalmologist.
Teaching/ Discharge Planning	• Your instructions will be reviewed before you leave. • Ask any questions you may have before leaving.
Nutrition	• You will be offered a small drink and a cookie.
Activity/Safety	• **You will need a ride home.** • **You will leave the Eye Institute in a wheelchair. A $1.00 coin deposit is needed for the wheelchair.** • **Do not drive following your surgery.** • **Plan to have someone stay with you overnight.**
Medications/ Treatments/ Procedures	• Nausea is typically not a side effect of this procedure. If, at any time, you are sick to your stomach, please advise the nurse. • The nurse will remove your IV and apply a dressing before you go home. • If you are diabetic, you may have your blood sugar tested.

Notes:

Day(s) Following Your Surgery, After Your Procedure	
Clinical Assessment	• Your ophthalmologist will book follow-up appointments for you in his/her office.
Nutrition	• Resume your regular diet. • Do not drive until your ophthalmologist says that you can.
Activity/Safety	• Do not drink alcohol or use recreational drugs e.g., marijuana for 24 hours following your procedure. • Do not do activities where dirt, dust or objects can get into your eye or activities that require bending or heavy lifting. • Do not rub your eye. • Read the discharge instructions given to you for your ophthalmologist's specific do's and don'ts.
Medications/ Treatments	• Take the eye drops and medications ordered by your ophthalmologist. • Resume your normal medications, unless instructed otherwise.
Treatments/ Procedures	• If you see new floating spots, flashes of light, or experience severe pain before your follow-up appointment with your ophthalmologist, contact your surgeon or visit the Emergency Department.

Notes:

How to Administer Eye Drops



1. Wash your hands.
2. Do not touch the dropper opening.
3. Look upward.
4. Pull the lower eyelid down to make a ‘gutter’.
5. Bring the dropper as close to the ‘gutter’ as possible without touching it or the eye.
6. Apply the prescribed amount of drops in the ‘gutter’.
7. Close the eye for about two minutes. Do not shut the eye too tight.
8. Excess fluid can be removed with a tissue.
9. If more than one kind of eye-drop is used wait at least five minutes before applying the next drops

Reference: De Vries, T. P. G. M; Fresle, Daphne A; Henning, R.H; Hogerzeil, Hans (1994) Guide to Good Prescribing – A Practice Manual, WHO Headquarters in Geneva
Retrieved from: http://apps.who.int/medicinedocs/en/d/Jwhozip23e/7.3.1.html#Jwhozip23.7.3.1

Feedback Questionnaire

1. Did you find this booklet helpful? ❑ Yes ❑ No

2. Did you feel most of your questions were answered? ❑ Yes ❑ No

3. Did we forget or miss any information that you wanted? ❑ Yes ❑ No

   If yes, what did we forget?_____

   _____

4. Did the information help prepare you for surgery? ❑ Yes ❑ No

5. Was the information clear and easy to understand? ❑ Yes ❑ No

6. What information was most helpful _____

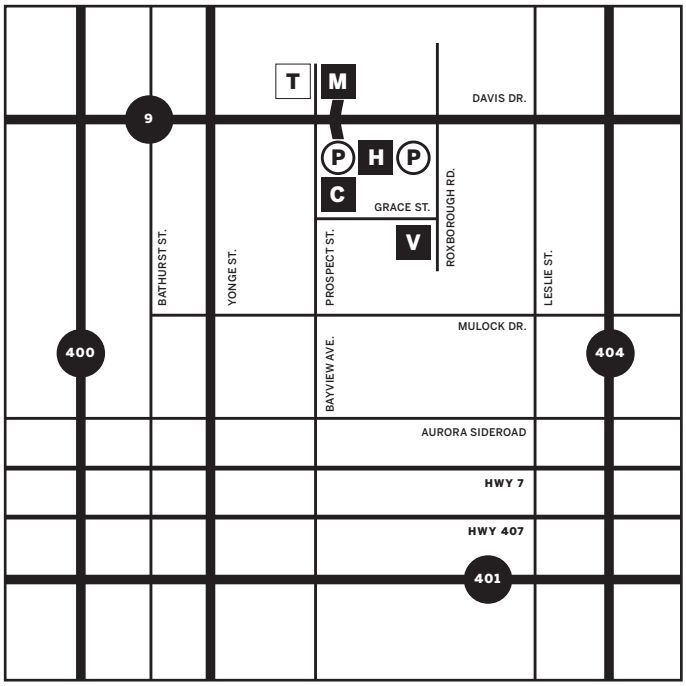
   _____

7. What information, if any, was least helpful? _____

   _____

Please bring this questionnaire with you on the day of your procedure.

HOW TO FIND US



M Medical Arts Building, 581 Davis Drive

V Southlake Village, 640 Grace Street

Southlake Foundation, 581 Davis Drive

H Southlake Regional Health Centre

C Stronach Regional Cancer Centre

T The Tannery Mall, 465 Davis Drive

P Parking

(Bridge over Davis Drive – accessible from P3 of the Parking Garage and Level 3 of the Medical Arts Building.

For more information, please contact:

The Eye Institute at Southlake

Medical Arts Building
581 Davis Drive
Newmarket, ON L3Y 2P6
Tel: (905) 895-4521 ext. 2930
TTY: (905) 952-3062
Fax: (905) 830-5977

southlake.ca

Re-Order #S0092_12 June. '23 Review Date: June. '26