SIGNATURE EYE SPECIALISTS

REFERRAL

From: _____
Tel: _____
Fax: _____

106, 280 Midpark Way SE.
Calgary, AB T2X 1J6
P: 403- 254-2408
F: 403- 254-5887

☐ Dr. B. Chow
☐ Dr. Y. Fodil-Cherif
☐ Dr. _____

We will contact your patient directly to arrange appointment at our clinic.

Reason for Referral: _____

Patient Name: _____ **DOB:** _____ **Alternate contact:** _____

Daytime Phone: _____ **Cell Phone:** _____ **Patient Email:** _____

Address: _____AHC #_____

Patient History Section

☐ Cataracts
☐ Diabetic Retinopathy
☐ Glaucoma
☐ Herpes Simplex Virus
☐ Iritis/ Uveitis
☐ Macular Degeneration
☐ Other: _____

☐ Arthritis
☐ Asthma/ COPD
☐ Diabetes
☐ Heart Disease/ Stroke
☐ High Blood Pressure

Impediments:
☐ Hearing
☐ Mobility
☐ Speech/ Language

Previous Ocular Hx/Surgery:

_____

ALLERGIES: _____

Current Medications: _____

_____

Examination Findings

OD

ucva: _____ corrected va: _____
MR: _____/_____x_____ bcva: _____
keratometry: _____
IOP: _____ method: NC TP Goldman
ocular movement: _____
_____
Lids/lashes: _____
_____
Cornea/Conj/Sclera _____
_____
Iris/pupil/AC: _____
_____
lens: _____
_____
Disc/retina: _____
_____

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