

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. A. Ragan
 Dr. _____

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

Patient Name: _____ **DOB:** _____
Phone (Daytime): _____ **Cell Phone:** _____ **Patient Email:** _____
Address: _____ **AHC#:** _____

Patient History Section

- Cataracts
 Diabetic Retinopathy
 Glaucoma
 Herpes Simplex Virus
 Iritis/ Uveitis
 Macular Degeneration
 Dry Eye

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

Other: _____

- Impediments:**
 Hearing
 Mobility
 Speech/ Language

Details: _____

Previous Ocular 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: _____

OS

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: _____