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. _____
☐ 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: _____

_____