SIGNATURE EYE SPECIALISTS

REFERRAL

From: _____
Tel: _____
Fax: _____

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

☐ 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:_____
_____

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