



North Hill Mall
 Suite 1705, 1632 14 Ave NW
 Calgary, AB T2N 1M7
Tel: 403 930 5900 **Fax:** 403 930 9933

REFERRAL FORM	<input type="checkbox"/> Routine	<input type="checkbox"/> Urgent	<input type="checkbox"/> OD	<input type="checkbox"/> OS	<input type="checkbox"/> BOTH
<input type="checkbox"/> Dr. Jamie Bhamra	<input type="checkbox"/> Dr. Micah Luong	<input type="checkbox"/> Dr. Helen Chung	<input type="checkbox"/> Dr. Brett Poulis	<input type="checkbox"/> Any Doctor	

PATIENT INFORMATION:

Name: _____ DOB: _____ Male Female
 AHC#: _____ Full Address: _____
 Phone/Cell: _____ Email: _____

REFERRING DOCTOR:

Name: _____ Practice ID#: _____
 Clinic: _____ Address: _____
 City: _____ Province: _____ Postal Code: _____
 Email: _____ Phone: _____ Fax: _____

NOTE: Email addresses are required to receive PDF Documents including encrypted patient diagnostics and treatment updates.

Please Complete	BCVA	Current Refraction (Date: _____)	Vertex Distance	IOP
Right Eye	20/			
Left Eye	20/			

COMMENTS (for referral selected below) _____

GENERAL REFERRAL:

- | | | | | | |
|--|---|---|----------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Cataract/Lens Dysfunction | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> SLT | <input type="checkbox"/> Uveitis | <input type="checkbox"/> Cornea | <input type="checkbox"/> Macula Optic |
| <input type="checkbox"/> Keratoconus | <input type="checkbox"/> YAG Caps/PI | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Orbit | <input type="checkbox"/> Iris/Pupil | <input type="checkbox"/> Nerve |
| <input type="checkbox"/> Pterygium | <input type="checkbox"/> CXL/PTK | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eyelid | <input type="checkbox"/> Lens | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Dry Eye/Allergy | <input type="checkbox"/> ICL/IOL Change | <input type="checkbox"/> Blurry/Vision Loss | <input type="checkbox"/> Sclera | <input type="checkbox"/> Vitreous | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blepharitis | <input type="checkbox"/> Tearing | <input type="checkbox"/> Conjunctiva | <input type="checkbox"/> Retina | | |

REFRACTIVE REFERRAL: RLE ICL PRK LASIK

Ocular History:	Medical HX:	Medications:	Pupils: OD _____ OS _____
<input type="checkbox"/> Injury	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Imitrex (migraine)	Prism: <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Amblyopia	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Accutane (acne)	
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Autoimmune	<input type="checkbox"/> Amiodarone (heart)	Dominance: <input type="checkbox"/> OD <input type="checkbox"/> OS
<input type="checkbox"/> Strabismus	<input type="checkbox"/> HSV/HZV	<input type="checkbox"/> Flomax (urinary flow)	
<input type="checkbox"/> Previous Eye Surgery	<input type="checkbox"/> Asthma/Allergies		
<input type="checkbox"/> Keratoconus	<input type="checkbox"/> _____		

Contact Lens Use: How Long? _____ Soft RGP Scleral Monovision Simulated

Current Spectacles Rx	OD:	OS:
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DRY EYE CENTRE OF EXCELLENCE REFERRAL:

Assess for Lid Treatments: MiBoFlo LipiFlow Intense Pulsed Light (IPL) Radiofrequency (RF) BlephEx

Heated mask, artificial tears, omega 3 fatty acids, lid care: Would you like Vector to provide? Y N

Yes, I will participate in the Dry Eye and/or Refractive Co-Management Program. Please include full name of Optometrist or Physician for Co-management payments: _____