VECTOR EYE CENTRE

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

## REFERRAL FORM

☐ Routine ☐ Urgent | ☐ OD ☐ OS ☐ BOTH

☐ Dr. Jamie Bhamra ☐ Dr. Micah Luong ☐ Dr. Brett Poulis ☐ 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:**

☐ Cataract/Lens Dysfunction
☐ Keratoconus
☐ Pterygium
☐ Glaucoma
☐ YAG Caps/PI
☐ ICL/IOL Change
☐ Dry Eye/Allergy
☐ SLT
☐ Hypertension
☐ Diabetes
☐ Tearing
☐ Blepharitis
☐ CXL/PTK
☐ Conjunctiva
☐ Sclera
☐ Cornea
☐ Iris/Pupil
☐ Lens
☐ Retina
☐ Macula
☐ Medication
☐ Other: _____

**REFRACTIVE REFERRAL:** ☐ RLE ☐ ICL ☐ PRK ☐ LASIK

**Ocular History:**
☐ Injury
☐ Amblyopia
☐ Double Vision
☐ Strabismus
☐ Previous Eye Surgery
☐ Keratoconus

**Medical HX:**
☐ Diabetes
☐ Vascular Disease
☐ Autoimmune
☐ HSV/HZV
☐ Asthma/Allergies
☐ _____

**Medications:**
☐ Imitrex (migraine)
☐ Accutane (acne)
☐ Amiodarone (heart)
☐ Flomax (urinary flow)

**Pupils:** OD _____ OS _____

**Prism:** ☐ Y ☐ N

**Dominance:** ☐ OD ☐ OS

**Contact Lens Use:** How Long? _____ ☐ Soft ☐ RGP ☐ Scleral

☐ Monovision Simulated Target _____ OD: ☐ OS: ☐

| Current Spectacles Rx | OD: | OS: |
|---|---|---|

**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 Physican for Co-management payments: _____

**Instructions:** Fax Referral Form with supporting documents to Vector Eye Centre **Confidential Fax:** 403 930 9933