

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. 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 YAG	<input type="checkbox"/> SLT	<input type="checkbox"/> Blepharitis	<input type="checkbox"/> Cornea	<input type="checkbox"/> Macula
<input type="checkbox"/> Keratoconus	<input type="checkbox"/> Caps/PI	<input type="checkbox"/> Hypertension	<input type="checkbox"/> CXL/PTK	<input type="checkbox"/> Iris/Pupil	<input type="checkbox"/> Medication
<input type="checkbox"/> Pterygium	<input type="checkbox"/> ICL/IOL Change	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Conjunctiva	<input type="checkbox"/> Lens	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Dry Eye/Allergy	<input type="checkbox"/> Tearing	<input type="checkbox"/> Sclera	<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 Target _____ OD: OS:

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 Physican for Co-management payments: _____