

**REFERRAL FORM**
☐ Routine

☐ Urgent

☐ OD

☐ OS

☐ BOTH

☐ Dr. Jamie Bhamra

☐ Dr. Micah Luong

☐ Dr. Brett Poulis

☐ Dr. Ugo Dodd

☐ 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"/> Blepharitis | <input type="checkbox"/> Cornea     | <input type="checkbox"/> Macula       |
| <input type="checkbox"/> Keratoconus               | <input type="checkbox"/> YAG 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"/> Strabismus                | <input type="checkbox"/> Dry Eye/Allergy    | <input type="checkbox"/> Tearing      | <input type="checkbox"/> Sclera      | <input type="checkbox"/> Retina     |                                       |
| <input type="checkbox"/> Orthoptics Assessment     | <input type="checkbox"/> Binocular Diplopia |                                       |                                      |                                     |                                       |

**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 Physician for Co-management payments: \_\_\_\_\_