

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"/> Dry Eye/Allergy | <input type="checkbox"/> Tearing | <input type="checkbox"/> Sclera | <input type="checkbox"/> Retina | |

REFRACTIVE REFERRAL: ☐ RLE ☐ ICL ☐ PRK ☐ LASIK

Ocular History:

- ☐
- Injury
-
- ☐
- Amblyopia
-
- ☐
- Double Vision
-
- ☐
- 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:
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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: _____