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. 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:

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

DRY EYE CENTRE OF EXCELLENCE REFERRAL:

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

Has patient had previous IPL / RF / Lipiflow? ☐ Y ☐ N If yes, how many treatments?_____

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