



**Dr. Marvi Cheema**  
**Serac Eye and Skin Care Centre**  
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Tel: 403-234-6023 Fax: 403-243-1587

**REFERRAL FORM**

**Dr. Marvi Cheema, BSc, MD, FRCSC, DABO**

Cataract Surgery and Comprehensive Ophthalmology

**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Male/Female  
Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_  
PHN: \_\_\_\_\_

**REASON FOR REFERRAL:**  URGENT  ROUTINE      **EYE:**  RIGHT  LEFT  BOTH

<input type="checkbox"/> CATARACT SURGERY	<input type="checkbox"/> CHALAZION REMOVAL	<input type="checkbox"/> ECTROPION/ENTROPION
<input type="checkbox"/> LASER PERIPHERAL IRIDOTOMY	<input type="checkbox"/> EYELID LESION EXCISION	<input type="checkbox"/> FUNCTIONAL BLEPHAROPLASTY
<input type="checkbox"/> YAG CAPSULOTOMY	<input type="checkbox"/> PTERYGIUM EXCISION	<input type="checkbox"/> TEARING
<input type="checkbox"/> SLT/GLAUCOMA LASER	<input type="checkbox"/> IRIS/PUPIL	<input type="checkbox"/> KERATITIS
<input type="checkbox"/> IOP/ GLAUCOMA	<input type="checkbox"/> CONJUNCTIVA	<input type="checkbox"/> EPI/SCLERITIS
<input type="checkbox"/> UVEITIS	<input type="checkbox"/> CORNEA	<input type="checkbox"/> RETINA/VITREOUS
<input type="checkbox"/> AMD/MACULA	<input type="checkbox"/> OPTIC NERVE	<input type="checkbox"/> HYPERTENSION
<input type="checkbox"/> DIABETES	<input type="checkbox"/> DRY EYE	<input type="checkbox"/> CHLOROQUINE/ HYDROXYCHLOROQUINE TOXICITY SCREENING
		<input type="checkbox"/> _____

**COMMENTS:**

**REFERRING PHYSICIAN INFORMATION**

Physician Name: \_\_\_\_\_ Prac ID: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date: \_\_\_\_\_