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Edmonton, Alberta
T6L 6W6
Phone: 780.450.3335
Toll Free: 1.800.272.9697
Fax: 780.461.9430
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Referral Form

Date of Referral: _____

☐ ***Dr. Kassiri*** ☐ ***Dr. Dorey*** ☐ ***Dr. Riyaz*** ☐ ***Dr. Abuswider*** ☐ ***Dr. Rayat*** ☐ _____

Patient Information:

Name (Last, First) _____ DOB (Mth/Day/Yr) _____

Address _____ City _____ Postal Code_____

Preferred Telephone #_____ AHC #_____

Patient Mobility Status ☐ Walking ☐ Wheelchair - Can patient transfer? ☐ Yes ☐ No ☐ Male ☐ Female

Referring Doctor Information:

Name _____ Prac ID # _____

Clinic Name _____ Clinic Address _____

Clinic Phone # _____ Clinic Fax # _____

Patient Clinical Information:

Reason for Referral: _____ ☐ Preferred timeline (within ____ weeks) ☐ Non urgent

Ocular/Medical History:

Exam Data:

	OD	OS
BCVA		
IOP		
Slit lamp findings		
Fundus exam findings		

Cataract Referral: Would you like to co-manage for follow ups? ☐ Yes ☐ No

Is the patient interested in Toric or Multifocal IOL? (Requires additional testing) ☐ Yes ☐ No

Other information: