ALBERTA RETINA CONSULTANTS

Excellence in patient care, research and teaching

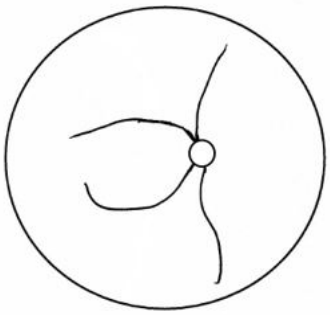
Fax 780·448·1809 Phone 780·448·1801 10924 107 Ave Edmonton

New Consultation Request: Please complete this consultation form and fax to our office. We will contact the patient directly by email or telephone. If the patient does not speak English, let them know to bring an interpreter to our office.

***Please ALSO send your usual referral letter to provide ancillary information**

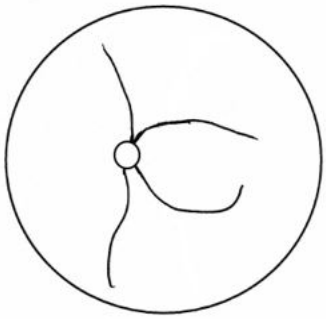
Patient Name (Last Name, First Name):
Date of Birth (yyyy,mm,dd):
Gender: PHN/ULI:
Address:
City: Postal Code:
Preferred Phone #: Alternate #:
Patient Email: (our contact preference)

Referring Doctor (Last Name, First Name):
PRAC ID#:
Office Address:
City: Postal Code:
Phone# Fax # and Location:
Date of Referral:
Family Physician:



Retinal Pathology

Please use retinal diagrams to identify location



Right Eye Diagnosis*	**Left Eye Diagnosis***
Right Eye VA:	**Left Eye VA:**

*Check off retinal diagnosis from list or write in above box

Other Comments:

_____

_____

_____

REFERRAL TIMES

Call *and speak to an ARC Physician directly.*
❒RD
❒Endophthalmitis
❒IOFB
❒CRAO

Urgent
❒Symptomatic RT/RH
❒NVG
❒VH

Semi-urgent
❒BRVO/CRVO
❒BRAO
❒CNV
❒CSR
❒DME (with VA↓)
❒Macular hole
❒Melanoma
❒PDR
❒Posterior Uveitis
❒PVD(Symptomatic)

Elective
❒Asymptomatic RT/RH
❒CHRPE
❒Dry AMD
❒ERM
❒Plaquenil
❒Lattice
❒Nevus
❒NPDR
❒PVD(Asymptomatic)
❒RAM
❒VMT