3215 49 Avenue, Suite 107 Red Deer, AB T4N 0M8
Ph: 403-340-1835 F: 403-340-2803
Monday to Friday: 8am - 4:30pm

Referral Form

Referring Physician:		**Practice ID:**	
Organization Name:		Phone:	
Address:		Fax:	
Patient Information			
Name:		Health Care Number:	
Phone:		D.O.B:	
Address:	City:	Province:	Postal Code:

Priority

☐ Routine: 3 months approx.
Screening for disease… diabetes, plaquenil, dry AMD, narrow angles, glaucoma.

☐ Semi-urgent: < 1 month
Flashes/floaters, wet AMD, stroke, ocular tumors, disc swelling, risk of vision loss but unclear.

☐ Urgent: < 1 week **In addition to a fax, please call and notify our office for all urgent referrals/requests.**
Giant cell arteritis, trauma, corneal ulcer, orbit cellulitis, imminent blindness within 24-48 hrs, acute high IOP>40.

Reason For Referral

Additional Details