Dr. Michael Ashenhurst/ Dr. Vivian Hill
Eye Physicians & Surgeons 933 17 Ave SW Suite #344
Calgary, AB T2T 5R6 Phone: 403-245-3171 Fax: 403-245-4205

MUST FILL IN ALL INFORMATION OR REFERRAL WILL BE REJECTED

Patient name_____DOB:_____

Address: _____AHC:_____

Telephone: Home:_____ Cell:_____

Family Physician: _____Fax:_____

Reason For referral: _____Dr. Hill ____Dr. Ashenhurst

____Cataracts ____Orbit/Thyroid Eye Disease

____Cosmetic ____Cosmetic Botox/fillers

____Lesion ____Pediatric Ophthalmic Concerns

____Ptosis/Lids ____Strabismus/ Diplopia

____Other repair ____Tearing

____Medical Botox ____**URGENT**

Details: Visual Acuity OD: _____ OS: _____ IOP: OD: _____ OS: _____

Refraction: OD_____OS_____

Comments:

_____

_____

_____

REFERRING DOCTOR (PRINT): _____

REFERRING DOCTOR ADDRESS: _____

PRAC ID: _____ FAX: _____ Phone: _____

Office Stamp:

____Optometrist
____Family Physician
____Ophthalmologist