Alberta Health Services
Alberta Children's Hospital

Vision Clinic
2888 Shaganappi Trail NW
Calgary, AB
T3B 6A8
403-955-7940 (ph)
403-955-7672 (fax)

Ophthalmology Referral

Soonest Available Appt _____ Dr. Cooper: _____
Dr. Astle: _____ Dr. Kherani (Ped Oculoplastics Only): _____

Required Demographics: Date of Referral: _____

Patient's Name: _____

Address: _____

Phone Number: _____

Birth Date: _____

Alberta Health Care Number: _____

Required Clinical Information:
Chief Concern (please be specific):

Cycloplegic Refraction: OD _____ VA: OD _____

OS _____ VA: OS _____
Please circle: with or without Rx

Were Glasses Prescribed? ____No ____Yes Rx given OD: _____

OS: _____

Other (Motility, Cover Testing, Fundus and Slit Lamp Exam):

Referring Optometrist: _____ PRACID: _____
(please print)

Address: _____

Phone Number: _____ Fax: _____

Appointment information will be faxed back to the referring optometrist to contact the patient. Please do not instruct the patient to contact our office in regards to this referral. Thank you.