Demong
Associate Eyecentre

Referral

From: _____

_____

_____

Phone: _____ Fax: _____

To: ☐ Dr. Thad Demong

☐ Cataract Consultation
☐ Corneal Consultation
☐ Other: _____

Please forward your findings by fax to: 403 254 1338
We will contact your patient directly to arrange the appointment.

Patient Name: _____ Alternate Contact Person: _____

Phone (Daytime): _____ Phone: _____ Relationship: _____

Patient History Section

☐ Cataracts
☐ Diabetic Retinopathy
☐ Glaucoma
☐ Herpes Simplex Virus
☐ Iritis/ Uveitis
☐ Macular Degeneration
☐ Other: _____

☐ Arthritis
☐ Asthma/ COPD
☐ Diabetes
☐ Heart Disease/ Stroke
☐ High Blood Pressure
☐ Other: _____

Impediments:
☐ Hearing
☐ Mobility
☐ Speech/ Language
☐ Other: _____

Details: _____

_____

Previous Ocular Surgery: _____

_____

ALLERGIES: _____

Current Medications: _____

_____

Examination Findings

Contact Lens Wear: ☐ No ☐ Yes: Type _____ Duration: (hr/days x yrs) _____ Last Worn: _____

OD

ucva: _____ corrected va: _____

MR: _____/_____x_____ bcva: _____

keratometry: _____

IOP: _____ method: _____

ocular movement: _____

_____

lids & lashes: _____

_____

cornea: _____

_____

iris & pupil: _____

_____

lens: _____

_____

retina: _____

_____

OS

ucva: _____ corrected va: _____

MR: _____/_____x_____ bcva: _____

keratometry: _____

IOP: _____ method: _____

ocular movement: _____

_____

lids & lashes: _____

_____

cornea: _____

_____

iris & pupil: _____

_____

lens: _____

_____

retina: _____

_____