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REFERRAL FORM

Please fax to 403-253-2102

Urgent_____ Semi-urgent_____ Non-urgent_____

Patient's Name:_____ **D.O.B:**_____ **Healthcare number:**_____

Parent(s) Name:_____ **Address:**_____

(H):_____ **(W):**_____ **(C):**_____ **Family physician:**_____

Date of referral:_____

Reason(s):

Pediatric strabismus	____	_____
Tearing	____	_____
Lid lesion(s)	____	_____
Ptosis	____	_____
Adult strabismus/diplopia	____	_____
Other	____	_____

Details: VA **OD** _____ **OS** _____

Refraction: **OD** _____ **OS** _____

Glasses including prisms: **OD** _____ **OS** _____

Additional comments:_____

_____

_____

_____

_____

Referring Dr:_____ **Prac #:**_____ **Fax:**_____

Address:_____