GIMBEL EYE CENTRE®

Cataract Surgery Assessment & Referral

Patient referred for: ☐ Cataract Assessment ☐ Primary Cataract
☐ Secondary Cataract/YAG laser Tx ☐ 2nd Opinion on Previous Cataract Sx

Referral Date (m/d/y): _____

Patient Name (Dr./Mr./Mrs./Ms./Miss): _____ Sex: ☐ Female ☐ Male

DOB (m/d/y): _____ Alberta Health Care #: _____

Address: _____ E-mail: _____

Telephone (res): _____ (bus): _____ (cell): _____

City: _____ Prov/State: _____ Postal/Zip: _____

If the Patient may not be reached or would have difficult answering questions, please indicate a contact person below:

Name of Contact Person: _____ Relationship to Patient: _____

Telephone (res): _____ (bus): _____ (cell): _____

Assessing Doctor Name: _____ Type of doctor: ☐ OD ☐ MD ☐ OPH

Address: _____ PRACID #: _____

Telephone: _____ Facsimile: _____

City: _____ Prov/State: _____ Postal/Zip: _____

Patient Health History

Ocular History (e.g., Injury, Amblyopia, Dry Eye, etc.): _____

If Patient has had previous eye surgery, please indicate type of sx: OD _____

OS _____

Name of Surgeon: _____ Location: _____

Date of Sx (m/d/y): _____ Was a lens implanted? ☐ Yes ☐ No

Please Check:

☐ Diabetes	☐ Mobility Problem	☐ Benign Prostatic Hypertrophy	☐ Heart
☐ Asthma	☐ Auto Immune Disease	☐ Immune Deficiency	☐ Language Difficulty
☐ Hepatitis	☐ Ocular Herpes Zoster	☐ Ocular Herpes Simplex	☐ Hearing Difficulty
☐ Atopy	☐ Pregnancy/Nursing	☐ Collagen Vascular Disease	☐ Hypertension

☐ Other health problems or concerns (If yes, please specify): _____

List medications, include Imitrex® (migraine), Accutane® (acne), Amiodarone® (cardiac anti-arrhythmic) &/or Flomax® (urinary flow):

Ocular: _____ Systemic: _____

_____ _____

_____ _____

List allergies to food (include nuts and shellfish) medications, surgical tape, eye drops, iodine &/or latex:

_____

_____ Specify if allergies are: ☐ Airborne ☐ Contact

PLEASE COMPLETE BOTH SIDES OF THIS FORM

GIMBEL EYE CENTRE®

Cataract Surgery Assessment & Referral cont'd

Patient Name: _____

Does Patient have cataracts? ☐ Yes ☐ No If *Yes*, indicate: ☐ OD ☐ OS

Does Patient have glaucoma? ☐ Yes ☐ No If *Yes*, indicate: ☐ OD ☐ OS

Current or last IOP: _____ OD _____ OS

IOP measured by: ☐ AT ☐ NCT

Does Patient have macular degeneration? ☐ Yes ☐ No If *Yes*, indicate: ☐ OD ☐ OS

Any abnormalities of the cornea? ☐ Yes ☐ No If *Yes*, indicate: ☐ OD ☐ OS

If *Yes*, please explain: _____

Any abnormalities of the iris? ☐ Yes ☐ No If *Yes*, indicate: ☐ OD ☐ OS

If *Yes*, please explain: _____

Best Corrected Visual Acuity OD 20/ _____ OS 20/ _____

Current Spectacles Rx OD _____ OS _____

Does the patient wear prism(s) in his/her current spectacles? ☐ Yes ☐ No

Would you prefer that our office (Calgary or Edmonton) performed follow-up care? ☐ Yes ☐ No ☐ Other

If *Other*, please specify: _____

Does Patient wear contact lenses? ☐ Yes ☐ No

If *Yes*, indicate: ☐ Hard ☐ Soft ☐ Rigid Gas Permeable ☐ Other, please specify: _____

☐ Instructed to leave out contact lenses for _____ days prior to assessment

Comments: _____

Has Gimbel Eye Centre seen this Patient previously? ☐ Yes ☐ No

Signature of Assessing Doctor: _____

For GEC Office Use Only

Patient ID: _____

Appointment Date: _____ Appointment Type: _____

Comments: _____

☐ Gimbel Eye Centre - Calgary Fax: (403) 202-3338 ☐ Gimbel Eye Centre - Edmonton Fax: (780) 452-4114