seema
eye care centre

☐ **Dr. Ahmed Al-Ghoul**
☐ **Dr. Vikram Lekhi**
☐ **Dr. Richard Leger**
☐ *Or First Available*

FAX REFERRAL FORM TO (403)-253-8608

Patient Name:_____ DOB:_____AHC: _____

Address: _____Telephone:_____

Email: _____

Reason for Referral: ☐ **Urgent** ☐ **Routine** ☐ **Right** ☐ **Left** ☐ **Both**

Eye lids / Orbit			
☐ Lesion Removal	☐ Droopy Lids	☐ Botox	☐ Blepharospasm
Cornea / Conjunctiva			
☐ Keratoconus/CXL	☐ Dry Eye	☐ Transplant	☐ Pterygium
☐ Infection	☐ Corneal Erosion/Abrasion	☐ PTK	☐ Other
Cataracts			
☐ Yag Laser	☐ Cataract Surgery	☐ Lens Issue	☐ Secondary IOL Repair
Glaucoma			
☐ Narrow Angle	☐ Medical Treatment	☐ Laser Treatment	
Uveitis/Inflammatory			
☐ Anterior	☐ Posterior	☐Auto-immune Disease (Rheumatoid,Thyroid, etc)	
Retina Screening			
☐ Retinal Tear	☐ Retinal Detachment	☐ Myopia	☐ Other

Screening:			
☐ Glaucoma	☐ Diabetes	☐ Macular Degeneration	☐ Flashes/Floaters
☐ Dry Eye	☐ Pediatric	☐ Nevus Screening	☐ Medication (Plaquenil, etc)
☐ Tearing	☐ Vision Loss	☐ Other: _____	

Comments:

Referring Doctor: ☐**Optometrist** ☐**GP** ☐**ER** ☐**Internal Medicine** ☐**Ophthalmologist** ☐**Other** _____

Doctor Name:	Prac ID:
Office Phone :	Office Fax:
Date of Referral:	Clinic Name:

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