

REFERRAL

From: _____
Tel: _____
Fax: _____

106, 280 Midpark Way SE
Calgary, AB T2X 1J6
P: 403-254-2408
F: 403-254-5887
E: info@signatureeye.ca

☐ Dr. B. Chow
☐ Dr. Y. Fodil-Cherif
☐ Dr. _____
☐ Dr. _____

We will contact your patient directly to arrange appointment at our clinic.

Patient Name: _____ DOB: _____
Phone (Daytime): _____ Cell Phone: _____ Patient Email: _____
Address: _____ AHC#: _____

Patient History Section

☐ Cataracts
☐ Diabetic Retinopathy
☐ Glaucoma
☐ Herpes Simplex Virus
☐ Iritis/ Uveitis
☐ Macular Degeneration
☐ Dry Eye

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

Other: _____

Impediments:
☐ Hearing
☐ Mobility
☐ Speech/ Language

Details: _____

Previous Ocular Surgery: _____

ALLERGIES: _____

Current Medications: _____

Examination Findings

OD
ucva: _____ corrected va: _____
MR: _____ / _____ x _____ bcva: _____
keratometry: _____
IOP: _____ method: NC TP Goldman
ocular movement: _____

lids & lashes: _____

Cornea/ Conj/ Sclera _____

iris/ pupil/ AC: _____

lens: _____

Disc/ retina: _____

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