ALBERTA RETINA CONSULTANTS

Excellence in patient care, research and teaching

FAX 780·448·1809 Phone 780·448·1801

New Consultation Request: To ensure appropriate triage and scheduling for your patients, please fully complete this mandatory consultation form and fax to our office. We will contact the patient.

Patient Name (last name, first name): Gender:

Date of Birth (yyyy/mm/dd): ULI/PHN:

Address: City: Postal Code:

Preferred Phone #: Alternate #:

Our contact preference is email If patient consents, they must complete 'patient authorization for email communication' box and sign bottom of next page.

Referring Doctor (last name,first name): PRAC ID#:

Referring Office Address:

Phone#: Fax #: Date of Referral:

Family Physician (last name, first name): Fax # or Location:

Please **also** send your usual referral summary letter if helpful.

Reason for Referral: Please choose appropriate category below for triage

Immediate Referral: Physician please phone ARC and speak to one of the physicians directly.

❒ Retinal Detachment ❒ Endophthalmitis ❒ IOFB ❒ CRAO

Within 48 Hours:

❒ Retinal Tear (Acute, symptomatic) ❒ Retinal Hole (Acute, symptomatic)
❒ Neovascular Glaucoma ❒ VH ❒ Other _____

Within 1 Week:

Acute CNV (please choose): ○ *Wet AMD* ○ *Myopia* ○ *Subretinal Hemorrhage* ○ *Trauma*
❒ BRAO ❒ Macular Hole ❒ Melanoma ❒ PVD - symptomatic ❒ Other _____

Within 2 Weeks:

❒ BRVO ❒ CRVO ❒ Uveitis (Posterior only) ❒ PDR ❒ Other_____

Within 4-6 Weeks:

❒ CSME ❒ Retinal Tear (Asymptomatic) ❒ Retinal Hole (Asymptomatic) ❒ CSR
❒ RAM ❒ VMT ❒ ERM ❒ PVD - asymptomatic ❒ Other_____

Elective:

❒ NPDR ❒ dry AMD ❒ CHRPE ❒ Plaquenil (include dose and duration info) ❒ Lattice
❒ Nevus (send copies of previous photos if available) ❒ Other_____

Which is Problem Eye? ❒Right ❒Left Best Vision _____Right _____Left

Medications:

Drug Allergies:

General Health History:

Diabetes > ❒Pills ❒Insulin ❒ Diet Year Diagnosed _____ Last known A1C value:_____

❒Smoker ❒Asthma/COPD ❒Hypertension ❒Heart Disease ❒Stroke ❒Dialysis

Occupation:

Any other information ARC should know about this patient:

If patient does not speak English an interpreter should be available with the patient.

Please inform the patient that our office will communicate with them via email, if an email address has been provided.

PATIENT AUTHORIZATION FOR EMAIL COMMUNICATION

I would like to receive confirmation of my appointments with Alberta Retina Consultants by email.

• I will only use my personal e-mail address and personal devices to communicate with my provider (i.e. will not use work/school e-mail address or public computer as my personal information could be viewed by others).

• I will be responsible for maintaining any information regarding my care that I have saved onto my personal computer.

• I understand that this email authorization will be included in my permanent medical record at Alberta Retina Consultants.

• E-mail correspondence containing clinical or significant information will be entered into my permanent medical record at Alberta Retina Consultants.

• I agree to inform Alberta Retina Consultants in writing if my e-mail address changes.

I have read and agree with the information above;

My current e-mail address is: _____@_____

Signature: Date:

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