



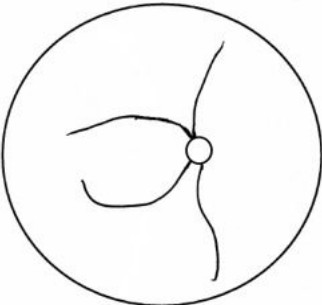
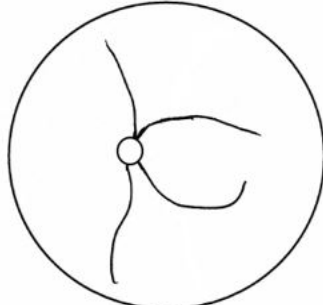
ALBERTA RETINA CONSULTANTS

Excellence in patient care, research and teaching

Fax 780-448-1809 Phone 780-448-1801 10924 107 Ave Edmonton

New Consultation Request: Please complete this consultation form and fax to our office. We will contact the patient directly by email or telephone. If the patient does not speak English, let them know to bring an interpreter to our office.

***Please ALSO send your usual referral letter to provide ancillary information**

<p>Patient Name (Last Name, First Name):</p> <p>Date of Birth (yyyy,mm,dd):</p> <p>Gender: PHN/ULI:</p> <p>Address: Postal Code:</p> <p>City: Alternate #:</p> <p>Preferred Phone #:</p> <p>Patient Email: (our contact preference)</p>	<p style="text-align: center;"><u>REFERRAL TIMES</u></p> <p>Call and speak to an ARC Physician directly.</p> <p><input type="checkbox"/> RD</p> <p><input type="checkbox"/> Endophthalmitis</p> <p><input type="checkbox"/> IOFB</p> <p><input type="checkbox"/> CRAO</p>						
<p>Referring Doctor (Last Name, First Name):</p> <p>PRAC ID#:</p> <p>Office Address:</p> <p>City: Postal Code:</p> <p>Phone# Fax # and Location:</p> <p>Date of Referral:</p> <p>Family Physician:</p>	<p><u>Urgent</u></p> <p><input type="checkbox"/> Symptomatic RT/RH</p> <p><input type="checkbox"/> NVG</p> <p><input type="checkbox"/> VH</p>						
 <div style="border: 1px solid black; padding: 10px; display: inline-block; text-align: center;"> <p>Retinal Pathology</p> <p>Please use retinal diagrams to identify location</p> </div> 	<p><u>Semi-urgent</u></p> <p><input type="checkbox"/> BRVO/CRVO</p> <p><input type="checkbox"/> BRAO</p> <p><input type="checkbox"/> CNV</p> <p><input type="checkbox"/> CSR</p> <p><input type="checkbox"/> DME (with VA↓)</p> <p><input type="checkbox"/> Macular hole</p> <p><input type="checkbox"/> Melanoma</p> <p><input type="checkbox"/> PDR</p> <p><input type="checkbox"/> Posterior Uveitis</p> <p><input type="checkbox"/> PVD(Symptomatic)</p>						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Right Eye Diagnosis*</td> <td style="width: 50%; padding: 5px;">Left Eye Diagnosis*</td> </tr> <tr> <td style="height: 30px;"></td> <td></td> </tr> <tr> <td style="padding: 5px;">Right Eye VA:</td> <td style="padding: 5px;">Left Eye VA:</td> </tr> </table>	Right Eye Diagnosis*	Left Eye Diagnosis*			Right Eye VA:	Left Eye VA:	<p><u>Elective</u></p> <p><input type="checkbox"/> Asymptomatic RT/RH</p> <p><input type="checkbox"/> CHRPE</p> <p><input type="checkbox"/> Dry AMD</p> <p><input type="checkbox"/> ERM</p> <p><input type="checkbox"/> Plaquenil</p> <p><input type="checkbox"/> Lattice</p> <p><input type="checkbox"/> Nevus</p> <p><input type="checkbox"/> NPDR</p> <p><input type="checkbox"/> PVD(Asymptomatic)</p> <p><input type="checkbox"/> RAM</p> <p><input type="checkbox"/> VMT</p>
Right Eye Diagnosis*	Left Eye Diagnosis*						
Right Eye VA:	Left Eye VA:						
<p>*Check off retinal diagnosis from list or write in above box</p> <p><u>Other Comments:</u></p> <hr/> <hr/> <hr/>							