ALBERTA RETINA CONSULTANTS

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Cornea, Cataract & Anterior Segment Referral Form

Patient Information: ***Date of Referral:*** ________________________________

Name (Last, First) ____DOB (MM/DD/Year) ____________________

Address ____________________________________ City ______________________ Postal Code _________________

Preferred Telephone #________________________________ AHC #____

Patient Mobility Status ☐ Walking ☐ Wheelchair - Can patient transfer? ☐ Yes ☐ No

Referring Doctor Information:

Name ____ Prac ID # ____

Clinic Name _______________________________ Clinic Address ____

Clinic Phone # _______________________________ Clinic Fax # ____

Patient Clinical Information:

Reason for Referral: ________________________________ ☐ Preferred timeline (within ____ weeks) ☐Non urgent

Ocular/Medical History:

Exam Data:

	OD	OS
BCVA		
IOP		
Slit lamp findings		
Fundus exam findings		

Cataract Referral: Would you like to co-manage for follow ups? ☐ Yes ☐ No

Is the patient interested in Premium IOLs (ex. Toric or Multifocal)? (Requires additional testing)

☐ Yes ☐ No

Other information: