103, 2731 Hewes Way
Edmonton, Alberta
T6L 6W6
Phone: 780.450.3335
Toll Free: 1.800.272.9697
Fax: 780.461.9430
www.albertaeyemd.com

REFERRAL FORM

Date of Referral:
☐ Dr.

Patient Information *(place label or complete below)*			
Name (Last, First)			DOB (Mon d, yyyy)
Address	City		Postal Code
Preferred Tel #	AHC #		☐ Male ☐ Female
Email Address			☐ Other: _____
Patient Mobility Status: ☐ Walking ☐ Walker ☐ Oxygen		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 – please attach copy of last visit:			
☐ Cataract	☐ Glaucoma	☐ Retina	☐ Cornea
☐ Refractive Surgery	☐ Lesions	☐ Lids	☐ Strabismus
☐ Other:			
Preferred Timeline:	☐ Within 1 month	☐ Within 3 months	☐ Within 6 months
Cataract/Glaucoma Referral - Would you like to co-manage for follow ups?		☐ Yes	☐ No
Additional Notes (if needed):			

Referrals are accepted by Referral Letter or Referral Form. Please fax to 780-461-9430