Suite 250, 10216 – 124th Street NW
Edmonton, AB T5N 4A3
Phone: 780-432-1261
Fax: 780-433-2247

Referral Form Date of Referral_____

☐ Dr. J. Leong-Sit ☐ Dr. D. Mah ☐ Dr. K. Kurji ☐ Dr. J. Ting ☐ First Available

Referring Doctor Information Name_____

Referral Doctor PRAC ID_____ Clinic Name_____

Clinic Address_____

Clinic Phone_____ Clinic Fax_____

Patient Information Name_____

DOB (M/D/Y)_____ ULI/PHN_____ ☐ Male ☐ Female ☐ Other

Address_____

Home Phone_____ Cell Phone_____

Email Address_____

Patient Mobility Status ☐ Walking ☐ Wheelchair – can patient transfer? ☐ Yes ☐ No

Reason for Referral ☐ Cataract Evaluation ☐ Corneal Evaluation ☐ Refractive Surgery

☐ Other _____

History

Medical History_____

Past Ocular History_____

Autorefract OD_____ K's OD_____

Autorefract OS_____ K's OS_____

UCVA OD_____ Manifest OD_____ BCVA OD_____ IOP OD_____

UCVA OS_____ Manifest OS_____ BCVA OS_____ IOP OS_____

Slit Lamp:_____

Comments (please attach letter if available)_____

_____

_____

Physician Signature: _____

Date: _____

PLEASE fax completed form to 780-433-2247