



Suite 250, 10216 – 124<sup>th</sup> 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    Dr. S. Nazarali    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: \_\_\_\_\_