

Please fax referral to: 403-255-7764

- ☐ Cataract
- ☐ Glaucoma / Glaucoma Suspect
- ☐ Narrow Angles / LPI
- ☐ YAG Capsulotomy
- ☐ Uveitis / Ocular inflammation
- ☐ Corneal Disease / Dry Eye
- ☐ Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Dermatochalasis / Ptosis
- ☐ Lid Lesion
- ☐ Other

- ☐ **Routine**
- ☐ **Semi-Urgent (1-4 weeks)**
- ☐ **Urgent (Within 1 week)**

Additional Comments:

Last Seen: _____ IOP: _____ OD _____ OS _____

Refraction OD: _____ VA: _____

OS: _____ VA: _____

Patient Name: _____ DOB: _____ PHN# _____

Phone: _____ Alternate Phone: _____

Referring Doctor: _____ Referring Office Fax #: _____

Referring Office Phone # _____ Date of Referral: _____

Practitioner ID#: _____ Doctor's Signature: _____

*24 hours notice is required to change or cancel an appointment or there will be a \$75.00 charge.