VISIONMAX
EYE CENTRE

# Primary Eye Care Provider Referral Form

Date: ______________________________

Patient Name (Dr./Mr./Ms./Miss):____________________________________________________________________________

Birthdate (m/d/y):_____________________________________________Examination Date:_____________________________________

Patient's Phone #: __________________ (Home) ____________________(Cell) Email:____________________________________

Alberta Health Care #: _________________________________ Sex: ☐ Male ☐ Female

Home Address:__________________________________________________________________________________________________________

City: _____________________________ Province: _________________________ Postal Code: __________________________

Patient Mobility: ☐ Walking ☐ Wheelchair Can the patient transfer to a surgical bed: ☐ Yes ☐ No

Can the patient lay flat for 30 minutes: ☐ Yes ☐ No

Assessing Doctor:_____________________________________________________ ☐ OD ☐ MD

Assessing Doctor's Clinic: ________________________________

Address:___________________________________________________________________________________________________________

Phone #: ___________________________________ Fax #: ___________________________________

***Reason for Referral:***

☐ Cataract Assessment ☐ Laser Vision Correction ☐ Implantable Collamer Lens (ICL) ☐ Keratoconus ☐ Dry Eye Assessment

☐ Presbyond ☐ Recurrent Epithelial Erosions ☐ Refractive Lens Exchange ☐ Other: _____________________

***Patient Information:***

| *Ocular Concerns:* | *Ocular History (ex. Previous eye surgery):* |
|---|---|
| *List of medications the patient is taking:* | *Allergies (include shellfish and latex):* |

| | *OD* | | *OS* | |
|---|---|---|---|---|
| *Current Spectacles Prescription:* | | | | |
| *Manifest Refraction:* | | | | |
| *Uncorrected Visual Acuity:* | 20/ | | 20/ | |
| *Best Corrected Visual Acuity:* | 20/ | | 20/ | |
| *Keratometry:* | K1: | K2: | K1: | K2: |
| *Pachymetry (If possible):* | | | | |
| *Contact Lens User?* | ☐ Soft ☐ Hard ☐ Toric ☐ Non-Toric Specifics: | | | |



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*Current Ocular Health:*

| | |
|---|---|
| *Anterior Chamber:* □ Quiet □ Occasional Cell □ Shallowed □ PDS □ PXF □ Hyphema | |
| *Ocular Motility:* □ Full □ Orthophoric □ Exotropia □ Esotropia □ Dissociated Vertical Deviation □ Other: ________________ | |
| *Conjunctiva:* □ Conjuctivitis □ Conjunctival Chalasis | |
| *Pupil:* □ Normal Reactive □ Mid-dilated □ Traumatic Mydriasis □ RAPD | |
| *Lids:* □ Normal □ Ectropion □ Entropion □ Ptosis □ Blepharitis □ Blepharochalasis □ MGD | |
| *Cornea:* □ Clear □ Haze □ Mild mid-peripheral haze □ Graft Clear □ Krukenberg Spindle □ Fuchs Endothelial Dystrophy □ Guttata □ Keratic Precipitates □ Bullous Keratopathy □SPK | |
| *Epithelium:* □ Intact □ Punctate Epithelial Erosion □ SPK □ Epithelial Defect | |
| *Iris:* □ Normal □ Patent PI □ Rubeosis Iriditis □ Iris Nodules | |
| *Lens:* □ Clear □ Nuclear Sclerosis □ Nuclear Cataract □ Cortical Cataract □ PSC □ Mixed Cataract □ Aphakic | |
| *IOL:* □ Well Centred □ Clear □ Multifocal □ Posterior Capsular Opacification | |
| *Vitreous:* □ Clear □PVD with Weiss Ring □Hemorrhage □Vitritis | |
| *Macula:* □ Normal □ Dry □ Edema □ CME □ CSME □ Microaneurysm □ Circinate Excudates □ Hemorrhage □ Macular Hole □ Drusen □ Fine Mottling □ Geographic Atrophy □ Others: _______________ | |
| *C/D:* _______________ | *IOP:* OD _________ OS_________ |
| *Confrontation Field:* □ Full | *Retina:* □Attached360 □Retinal Detachment □ Hole/Tear □ Lattice □ Other: _____________ |

*Additional Comments:*

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Assessing Doctor's Signature: ________________________________________



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