

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:

- Laser Vision Correction Implantable Collamer Lens (ICL) Keratoconus Dry Eye Assessment
- Presbyond Recurrent Epithelial Erosions Refractive Lens Exchange Other: _____

Patient Information:

<i>Ocular Concerns:</i>	<i>Ocular History (ex. Previous eye surgery):</i>
<i>List of medications the patient is taking:</i>	<i>Allergies (include shellfish and latex):</i>

	OD	OS
<i>Current Spectacles Prescription:</i>		
<i>Manifest Refraction:</i>		
<i>Uncorrected Visual Acuity:</i>	20/	20/
<i>Best Corrected Visual Acuity:</i>	20/	20/
<i>Keratometry:</i>	K1: K2:	K1: K2:
<i>Pachymetry (If possible):</i>		
<i>Contact Lens User?</i>	<input type="checkbox"/> Soft <input type="checkbox"/> Hard <input type="checkbox"/> Toric <input type="checkbox"/> Non-Toric Specifics:	

Current Ocular Health:

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

Additional Comments:

Assessing Doctor's Signature: _____