Primary Eye Care Provider Referral Form

Date: ___________________________

Patient Name (Dr./Mr./Ms./Miss)	First name:	Last name:
Birthdate (mm/dd/yyyy):	Email:	
Alberta Health Care #:	Contact #:	Sex: ☐ Male ☐ Female
Home Address:		

Assessing Doctor: ☐ OD ☐ MD	Examination Date (mm/dd/yyyy) :
Assessing Doctor's Clinic:	
Address:	
Phone #:	Fax #:

Reason for Referral: ____

☐ RLE ☐ ICL ☐ Laser Refractive Surgery ☐ Others: ______________________________________

	OD	OS
Current Spectacles Rx/Prism:		
Manifest Refraction and Acuity:	VA: 20/	VA: 20/
Contact Lens User?	☐ Soft ☐ Hard ☐ Toric ☐ Non-Toric	Specifics:

Current Ocular Health:

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Additional Comments:

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Assessing Doctor's Signature: ________________________________

Fax: 780-452-4114