



### 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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address:		

Assessing Doctor:	<input type="checkbox"/> OD <input type="checkbox"/> 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?	<input type="checkbox"/> Soft Non-Toric <input type="checkbox"/> Soft Toric <input type="checkbox"/> Hard Non-Toric <input type="checkbox"/> Hard Toric    Specifics:	

**Current Ocular Health:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional Comments:**  
\_\_\_\_\_  
\_\_\_\_\_

Assessing Doctor's Signature: \_\_\_\_\_