VISIONMAX EYE CENTRE

Primary Eye Care Provider Referral Form

Date: _____

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

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

Reason for Referral: _____

☐ CLR* ☐ ICL ☐ Laser Refractive Surgery ☐ Others: _____

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

Current Ocular Health:

_____

_____

_____

_____

Additional Comments:

_____

_____

Assessing Doctor's Signature: _____

*Custom Lens Replacement (CLR), previously called Refractive Lens Exchange (RLE).

Fax: 780-452-4114