CLEARVIEW
EYE CENTRE

PATIENT REFERRAL FORM

Please Fax to (403) 253-1138

☐ Dr. Ryan Yau
- Cataract
- Refractive
- Comprehensive
- Eyelids
- Glaucoma
- Strabismus

☐ Dr. Feisal Adatia
- Retina - Medical & Surgical
- Cataract

☐ Dr. Monique Munro
- Retina - Adult & Pediatric
- Uveitis

☐ Dr. Jason Wesolosky
- General

PATIENT DEMOGRAPHICS

Patient Name: _____ D.O.B: _____

Phone #: _____ AHC #: _____

Address: _____ Email: _____

REFERRING CLINIC INFORMATION

Referring Physician: _____ Clinic Name: _____

Phone: _____ Fax: _____ Referral Date: _____

Email: _____ Practice ID#: _____

Urgency of Referral: ☐ Urgent ☐ Elective Co-Management of this patient is desired: ☐ Yes ☐ No

REASON FOR REFERRAL

☐ ARMD (wet/dry)	☐ Epiretinal Membrane	☐ Cataract	☐ Dry Eyes
☐ CRVO/BRVO	☐ Macular Hole	☐ Refractive Lens Exchange	☐ Eyelids
☐ Diabetic Retinopathy	☐ Vitreomacular Traction	☐ Refractive Laser/ICL	☐ Lacrimal
☐ Diabetic Macular Edema	☐ Nevus	☐ YAG/SLT Laser	☐ Cornea/Pterygium
☐ CSR	☐ Plaquenil	☐ Narrow Angles	☐ Strabismus: Adult/Child
☐ Retinal Tear/Hole	☐ Uveitis	☐ Glaucoma	☐ Other: _____

VA OD _____ OS _____ IOP OD _____ OS _____

COMMENTS

403-253-1118 403-253-1138 www.clearvieweyecentre.com #100, 5340 1st St. SW, Calgary, AB T2H 0C8

Located within the Southern Alberta Eye Center