VECTOR EYE CENTRE

BRETT POULIS M.D., PH.D., F.R.C.S.C

North Hill Mall
Suite 1705, 1632 14 Ave NW
Calgary, AB T2N 1M7
Tel: 403 930 5900 **Fax:** 403 930 9933

Referral Form

☐ Routine ☐ Urgent | ☐ OD ☐ OS ☐ Both

For Transfer of Care ☐ Yes ☐ No

Co-Management Desired ☐ Yes ☐ No

Patient Information

Name: ______________________ DOB: ______________ ☐ Male ☐ Female

AHC#: ______________________

Phone (Home): ______________________ Phone (Cell): ______________________

Referring Doctor | Type/Print/Stamp here or provide information on fax header page

Name: ______________________ Practice ID#: ______________________

Clinic: ______________________ Address: ______________________

City: ______________ Province: ______________ Postal Code: ______________

Phone: ______________________ Fax: ______________________

NOTE: *Email addresses are required to receive PDF Documents including encrypted patient diagnostics and treatment updates.*

External Anatomy

☐ Dry Eye/Blepharitis/ Allergy
☐ Tearing/Epiphora
☐ Eyelid
☐ Conjunctiva
☐ Pterygium

Anterior Segment

☐ Cornea
☐ Uveitis
☐ Iris/Pupil
☐ Cataract/Lens Dysfunction
☐ YAG Capsulotomy/PCO
☐ Glaucoma
☐ YAG LPI/Narrow Angles

Posterior Segment

☐ Flashes/Floaters
☐ AMD
☐ Diabetes
☐ Hypertension
☐ Retina
☐ Macula
☐ Optic Nerve

Other

☐ Blurry/Vision Loss
☐ Plaquenil Screening
☐ Amiodarone Screening
☐ Other:

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Comments *(for referral selected above)*:

Instructions: *Fax Referral Form with supporting documents to Vector Eye Centre Confidential Fax: 403 930 9933*