

**Dr. Robert Mitchell**  
General  
Cataract  
Refractive

**Dr. Patrick Mitchell**  
Retina Medical and Surgical  
Cataract

**Dr. Feisal Adatia**  
Retina Medical and Surgical  
Cataract

**Dr. Ryan Yau**  
General  
Cataract  
Refractive  
Strabismus (adult/pediatric)  
Lids & External Disease

**Dr. Brett Poulis**  
General  
Uveitis

**Dr. Jason Wesolosky**  
General

**Patient Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

AHC# \_\_\_\_\_

**Referring Clinic Information**

Referring Physician: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date: \_\_\_\_\_

Practice ID# : \_\_\_\_\_

Urgency of Referral:  Urgent  Within a Week  Within a Month  Elective

This referral is for transfer of care: Yes or No

Co-Management of this patient is desired: Yes or No

**Conditions**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> ARMD (wet / dry)     | <input type="checkbox"/> Macular Hole           | <input type="checkbox"/> Cataract           | <input type="checkbox"/> Optic Nerve                 |
| <input type="checkbox"/> Vein Occlusion       | <input type="checkbox"/> Vitreomacular Traction | <input type="checkbox"/> Conjunctiva        | <input type="checkbox"/> Pterygium                   |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Vitreous Detachment    | <input type="checkbox"/> Cornea             | <input type="checkbox"/> Refractive                  |
| <input type="checkbox"/> Diabetic Maculopathy | <input type="checkbox"/> Retinal Detachment     | <input type="checkbox"/> Dry Eye            | <input type="checkbox"/> Strabismus (adult/children) |
| <input type="checkbox"/> Retinal Tear/Hole    | <input type="checkbox"/> Mac On/Off             | <input type="checkbox"/> Eyelid/Orbit       | <input type="checkbox"/> Sudden Loss of Vision       |
| <input type="checkbox"/> Epiretinal Membrane  | <input type="checkbox"/> Retinal Lesion         | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Uveitis                     |
|   | <input type="checkbox"/> Nevus                  | <input type="checkbox"/> Lacrimal / Tearing | <input type="checkbox"/> Other                       |

Comments \_\_\_\_\_

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Please fax this form to our office at (403) 258-2704 with any supplement workup/information