Assessment & Referral Form

Patient referred for: ☐ Cataract Assessment/Second Opinion ☐ Retina
☐ Secondary Cataract/YAG laser Tx ☐ Glaucoma

Referral Date (m/d/y): ______________________

Patient Name (Dr./Mr./Mrs./Ms./Miss): ______________________ Sex: ☐ Female ☐ Male

DOB (m/d/y): ______________________ Alberta Health Care #: ______________________

Address: ______________________ E-mail: ______________________

Telephone (res): ______________ (bus): ______________ (cell): ______________

City: ______________ Prov/State: ______________ Postal/Zip: ______________

If the Patient may not be reached or would have difficult answering questions, please indicate a contact person below:

Name of Contact Person: ______________________ Relationship to Patient: ______________________

Telephone (res): ______________ (bus): ______________ (cell): ______________

Assessing Doctor Name: ______________________ Type of doctor: ☐ OD ☐ MD ☐ OPH

Address: ______________________ PRACID #: ______________________

Telephone: ______________________ Facsimile: ______________________

City: ______________ Prov/State: ______________ Postal/Zip: ______________

Patient Health History

Ocular History (e.g., Injury, Amblyopia, Dry Eye, etc.): ______________________

____

If Patient has had previous eye surgery, please indicate type of sx: OD ______________________

OS ______________________

Name of Surgeon: ______________________ Location: ______________________

Date of Sx (m/d/y): ______________________ Was a lens implanted? ☐ Yes ☐ No

Please Check:

☐ Diabetes	☐ Mobility Problem	☐ Benign Prostatic Hypertrophy	☐ Heart
☐ Asthma	☐ Auto Immune Disease	☐ Immune Deficiency	☐ Language Difficulty
☐ Hepatitis	☐ Ocular Herpes Zoster	☐ Ocular Herpes Simplex	☐ Hearing Difficulty
☐ Atopy	☐ Pregnancy/Nursing	☐ Collagen Vascular Disease	☐ Hypertension

☐ Other health problems or concerns (If yes, please specify):

____

List medications, include Imitrex® (migraine), Accutane® (acne), Amiodarone® (cardiac anti-arrhythmic) &/or Flomax® (urinary flow):

Ocular: ______________________ Systemic: ______________________

______________________ ______________________

______________________ ______________________

List allergies to food (include nuts and shellfish) medications, surgical tape, eye drops, iodine &/or latex:

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______________________ Specify if allergies are: ☐ Airborne ☐ Contact

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Assessment & Referral Form cont'd

Patient Name: ____

Does Patient have cataracts? ☐ Yes ☐ No If *Yes*, indicate: ☐ OD ☐ OS

Does Patient have glaucoma? ☐ Yes ☐ No If *Yes*, indicate: ☐ OD ☐ OS

Current or last IOP: ____________ OD______ OS

IOP measured by: ☐ AT ☐ NCT

Does Patient have retinal pathology? ☐ Yes ☐ No If *Yes*, indicate: ☐ OD ☐ OS

Any abnormalities of the cornea? ☐ Yes ☐ No If *Yes*, indicate: ☐ OD ☐ OS

If *Yes*, please explain: ____

____

Any abnormalities of the iris? ☐ Yes ☐ No If *Yes*, indicate: ☐ OD ☐ OS

If *Yes*, please explain: ____

____

Best Corrected Visual Acuity OD 20/ ____________ OS 20/ ____________

Current Spectacles Rx OD ____________ OS ____________

Does the patient wear prism(s) in his/her current spectacles? ☐ Yes ☐ No

Would you prefer that our office performed follow-up care? ☐ Yes ☐ No ☐ Other

If *Other*, please specify: ____

Does Patient wear contact lenses? ☐ Yes ☐ No

If *Yes*, indicate: ☐ Hard ☐ Soft ☐ Rigid Gas Permeable ☐ Other, please specify: ____________

☐ Instructed to leave out contact lenses for _____days prior to assessment

Comments: ____

____

____

____

Has Gimbel Eye Centre seen this Patient previously? ☐ Yes ☐ No

Signature of Assessing Doctor: ________________________

For Office Use Only

Patient ID: ____

Appointment Date: ____________________ Appointment Type: ____________________

Comments: ____

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☐ **Gimbel Eye Centre Calgary** Fax: (403) 286-2943 ☐ **Gimbel Eye Centre Calgary** Phone: (403) 286-3022