GIMBEL EYE CENTRE

PATIENT REFERRAL FORM

PLEASE FAX TO (403) 286-2943

☐ **Dr. Kevin Warrian**
- Retina - Surgical
- Cataract

☐ **Dr. Adam Muzychuk**
- Refractive Surgery
- Cataract

☐ **Dr. John van Westenbrugge**
- Refractive Surgery

☐ **Next Available**

PATIENT DEMOGRAPHICS

Patient Name: _____ **D.O.B:** _____ *dd/mm/yyyy*

Phone Number: _____ **Number Cellular:** _____ **AHC:** _____

Address: _____

Email: _____

REFERRING CLINIC INFORMATION

Referring Physician: _____ Clinic Name: _____

Practice ID: _____ Referral Date: _____

Phone Number: _____ Fax: _____ Email: _____

REASON FOR REFERRAL

☐ CNV
☐ CRVO /BRVO
☐ Macular Hole (VA < 20/30)
☐ PDR
☐ Vitreous Hemorrhage
☐ WetAMD/nAMD
☐ Retinal Detachment/Tear
☐ YAG
☐ Cataract
☐ Refractive Lens Exchange
☐ Refractive Laser
☐ ICL

☐ OTHER: _____

VA OD _____ OS _____ IOP OD _____ OS _____

COMMENTS:

_____

PHONE NUMBER: 403-286-3022 FAX NUMBER: 403-286-2943 ADDRESS: #450. 4935 -40 Avenue NW Calgary, Alberta T3A 2N1
Located in the Market Mall Professional Building