# Jamie Bhamra BSc MD FRCSC

**Corneal and Cataract Surgery, Cornea Crosslinking**
**Medical Cornea and External Disease, Comprehensive Ophthalmology**

Fax referral form to **(403) 253-8608**

Patient Name: _____ DOB: _____ AHC: _____

Address: _____ Telephone: _____

Email:

**Reason for referral: URGENT ☐ ROUTINE ☐** **EYE: Right ☐ Left ☐ Both ☐**

| | | | |
|---|---|---|---|
| ☐ Cataract Surgery | ☐ Eyelid / Orbit | ☐ Blepharitis | ☐ Uveitis |
| ☐ Cornea Transplant | ☐ Sclera | ☐ Lacrimal / Tearing | ☐ Retina Detachment |
| ☐ DSAEK | ☐ Episclera | ☐ Conjunctivitis | ☐ Retina Tear/ Hole |
| ☐ Cornea Crosslinking | ☐ Conjunctiva | ☐ Dry Eye | ☐ Retina Lesion |
| ☐ Pterygium Surgery | ☐ Cornea | ☐ Keratoconus | ☐ ARMD |
| ☐ PTK | ☐ Lens | ☐ Cornea Ulcer | ☐ Macular Lesion |
| ☐ Trauma | ☐ Glaucoma | ☐ Cornea Erosions | ☐ Diabetes |
| ☐ Vision Loss | ☐ Retina/ Vitreous | ☐ Keratitis | ☐ Diploplia |
| ☐ Optical / Refractive | ☐ Optic Nerve | ☐ Epi / Scleritis | ☐ Other |

**Comments:**

Examination

| | Best Corrected Vision | Refraction | Intraocular Pressure |
|---|---|---|---|
| **Right Eye** | | | |
| **Left Eye** | | | |

Referring Clinic Information

Physician Name: _____

Prac ID: _____

Referring office telephone: _____

Referring office fax: _____

Date of referral: _____

**Referring Office Stamp**:

Rockyview Health Centre 2, Suite 110, 1016 – 68th Ave SW, Calgary AB T2V 4J2
Phone: (403) 253-5300 Fax: (403)253-8608 www.seemaeye.com