seema
eye care centre

FAX REFERRAL FORM TO 403- 253- 8608

- ☐ **Dr. Ahmed Al-Ghoul**
- ☐ **Dr. Vikram Lekhi**
- ☐ **Dr. John McWhae**
- ☐ **Dr. Jason Wesolosky**
- ☐ **Dr. Sophia Leung**
- ☐ *Or First Available*

Patient Name: _____ DOB: _____ AHC: _____

Address: _____ Cell Phone: _____

Email* _____

Reason for Referral: ☐ **URGENT** ☐ **ROUTINE** ☐ **Right** ☐ **Left** ☐ **Both**

Eye lids / Orbit

☐ Lesion Removal ☐ Droopy Lids ☐ Botox ☐ Blepherospasm

Cornea / Conjunctiva

☐ Keratoconus/CXL ☐ Dry Eye ☐ Transplant ☐ Pterygium

☐ Infection ☐ Corneal Erosion ☐ PTK ☐ Other

Cataracts

☐ Yag Laser ☐ Cataract Surgery ☐ Lens Issue ☐ Secondary IOL Repair

Glaucoma

☐ Narrow Angle ☐ Medical Treatment ☐ Laser Treatment

Uveitis

☐ Anterior ☐ Posterior

Retina Screening

☐ Retinal Tear ☐ Retinal Detachment ☐ Myopia ☐ Other

Screening:

☐ Glaucoma ☐ Diabetes ☐ Macular Degeneration ☐ Flashes/Floaters

☐ Dry Eye ☐ Pediatric ☐ Nevus Screening ☐ Autoimmune Disease

☐ Diplopia ☐ Vision Loss ☐ Medication / Plaquenil / Aminoderone

Comments:

Referring Doctor: ☐ **OD** ☐ **GP** ☐ **ER** ☐ **Internal Medicine** ☐ **Ophthalmologist** ☐ **Other**

Doctor Name:	Prac ID:
Office Phone :	Office Fax:
Date of Referral:	Clinic Name:

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