

REFERRAL FORM

- Consult With: Next Available
 Dr. Patrick Gooi (Glaucoma, Advanced Anterior Segment, Cataract)
 Dr. Christopher Hanson (Comprehensive, Cataract)
 Dr. Malcolm Gooi (Comprehensive)
 Dr. Micah Luong (Comprehensive)
 Dr. Victor Penner (Glaucoma, Cataract)

- Medical Urgency: Within a Week Within a Month Routine: Next Available
 Urgent Glaucoma (Please fax 403.281.2471 **and** phone 403.281.0603)

PATIENT INFORMATION	
Name:	AHC#:
Date of Birth (yyyy-mm-dd):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	
Phone:	Cell:

Please inform the patient that they will need to bring an interpreter to their appointment if they are unable to communicate in English.

REFERRING CLINIC INFORMATION	
Referring Physician:	Referring Clinic:
Phone:	Fax:
Practice ID #:	Date (yyyy-mm-dd):
This referral for transfer of care: <input type="checkbox"/> Yes <input type="checkbox"/> No	Co-Management of this patient is desired? <input type="checkbox"/> Yes <input type="checkbox"/> No

CONDITION(S)				
<input type="checkbox"/> Medical Glaucoma	<input type="checkbox"/> Cataract	<input type="checkbox"/> Cornea	<input type="checkbox"/> AMD (Wet / Dry)	<input type="checkbox"/> Sudden Loss of Vision
<input type="checkbox"/> Surgical Glaucoma	<input type="checkbox"/> YAG Capsulotomy	<input type="checkbox"/> Dry Eye	<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Pediatric
<input type="checkbox"/> Narrow Angles / LPI	<input type="checkbox"/> Dislocated IOL / Lens	<input type="checkbox"/> Pterygium	<input type="checkbox"/> Amblyopia	<input type="checkbox"/> Uveitis
<input type="checkbox"/> SLT / MLT	<input type="checkbox"/> IOL Opacity / Dysphotopsia	<input type="checkbox"/> Ptosis	<input type="checkbox"/> Strabismus	<input type="checkbox"/> Other:
<input type="checkbox"/> Cyclophotocoagulation	<input type="checkbox"/> Iris Defect	<input type="checkbox"/> Thyroid Eye Disease	<input type="checkbox"/> Plaquenil	
<input type="checkbox"/> Optic Nerve		<input type="checkbox"/> Lipid Mass / Chalazion		
VA: OD	OS	IOP: OD	OS	
Comments:				

Thank you for your referral. All referrals are triaged throughout the day and patients are generally called within 3 business days of receiving the referral. If medically urgent, please specify and ensure to send all relevant medical documents with the patient. Your office will be notified by fax of patient's appointment.

Cloudbreak Eye Care is committed to maintaining an accessible environment for persons with disabilities in the delivery of its goods and services. Our facility is wheelchair accessible.