



REFERRAL FORM

(clinics are permitted to use their own form)

Preferred Location: Abbotsford Maple Ridge Surrey Coquitlam (January 2018)

Preferred Doctor: Dr. Chu Dr. King Dr. Moosbrugger Other _____

Date (mm/dd/yr): _____ Referring Doctor & MSP#: _____

PATIENT INFORMATION

Name: _____ DOB (mm/dd/yr): _____

PHN#: _____

Address: _____

Home/Cell Tel #: _____ Work/Alternative Tel: _____

Diagnosis: _____

History & Examination: _____

Please indicate request(s) if appropriate:

- Cataract Evaluation (urgent/non-urgent)
- LASIK/PRK Evaluation
- Intraocular Collamer Lenses (ICLs)
- Refractive Lens Exchange (RLE) Evaluation
- Routine Evaluation
- Corneal Cross Linking
- Humphrey Visual Field (HVF)
- Optical Coherence Tomography (OCT)
- Other (urgent/non-urgent) _____

Cornea:

- Pterygium/Pinguecula
- Recurrent Erosion/Dystrophy
- Dry Eye

Laser:

- SLT
- YAG LPI
- YAG Capsulotomy
- Retinal Laser Photocoagulation

Retina:

- Diabetes
- Age-Related Macular Degeneration
- Vein Occlusions

Neuro-Ophthalmology:

- Botox for Blepharospasm
- Botox for Hemifacial Spasm

Glaucoma:

- Evaluation
- iStent

Oculo-Plastics:

- Entropion/ Ectropion
- Brow Lift/ Blepharoplasty
- Ptosis Repair
- Blocked Tear Duct
- Eyelid Lesion
- Chalazion
- Special Requests: _____