FRASER VALLEY
CATARACT & LASER

GENERAL MEDICAL AND SURGICAL OPHTHALMOLOGY

REFERRAL FORM

(clinics are permitted to use their own form)

Preferred Location: ◯ Abbotsford ◯ Maple Ridge ◯ Surrey ◯ Coquitlam

Preferred Doctor: ◯ Dr. Chu ◯ Dr. King ◯ Dr. Moosbrugger ◯ Dr. Payne ◯ Dr. Ekhlassi

◯ 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: ____

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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)____________________

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Oculoplastics:

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

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