RED ROCK OPHTHALMOLOGY

102 - 2505 17 Ave SW
Calgary, AB
T3E 7V3

Phone: 403-775-0076
Fax: 403-775-0042
www.redrockeye.ca

REFERRAL REQUEST - ☐ Please call patient to schedule ☐ Patient is scheduled:_____

Patient Information:

Name: _____ DOB:_____

AHC: _____

Address:_____

City: _____ Province: _____

Postal Code:_____Phone Number(s):_____

Referral Type:

- ☐ Emergency
- ☐ Cataract Evaluation
- ☐ Strabismus Evaluation
- ☐ Second Opinion
- ☐ Glaucoma Evaluation
- ☐ Retina Evaluation
- ☐ Other

_____

Accommodations needed: ☐ Wheelchair ☐ Interpreter ☐_____

Referring Doctor/Clinic:_____

Phone: _____ Fax:_____

Practitioner ID:_____

Reason for Consult/Primary Diagnosis: _____

_____

_____

_____

_____

Last Rx Date:_____ OD_____ 20/ ____ Manifest Rx OD_____ 20/___
OS_____ 20/ _____ Manifest Rx OS_____ 20/___

☐ I look forward to receiving your opinion and will resume general care following your consultation and management.
☐ I prefer to transfer this patient's medical care to you and your clinic.

Referring Doctor Signature:_____Date: _____

Please fax completed form to (403) 775-0042.