REFERRAL FORM

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PATIENT INFORMATION

Name: _____ AHC#: _____

Email: _____ Phone #:_____

REFERRING PROVIDER INFORMATION

Name: _____ PRAC ID: _____

Email: _____ Phone #:_____

Fax #:_____

REASON FOR REFERRAL (select all that apply)

- □ General Review
- □ Glaucoma Assessment
- □ Diabetic Checkup
- □ Paediatric Review
- □ Dry Eye Management
- □ Laser Treatment
- □ Electro Diagnostics
- □ Eye Lid lesions
- □ Low Vision Rehabilitation
- □ Ocular Aesthetics

SYMPTOMS (select all that apply)

- □ Pain
- □ Tearing
- □ Red Eye
- □ Ocular Deviation
- □ Decreased Vision
- □ Discharge
- □ Floaters
- □ Foreign Body Sensation
- □ Itchy/ Dry Eyes
- □ Eyelid Swelling
- □ Burning Sensation
- □ Flashes of Light
- □ Double vision
- □ Migraine

MEDICAL CONDITIONS (select all that apply)

- □ Herpes Simplex
- □ Herpes Zoster
- □ Atopic Dermatitis
- □ Atopic Eczema
- □ Ankylosing Spondylitis
- □ Systemic Lupus Erythematosus
- □ Neurofibromatosis
- □ Rheumatoid Arthritis
- □ Sarcoidosis
- □ Sjogren's Syndrome
- □ Hypertension
- □ Occlusive Vascular Disease
- □ Arterial Spasm (TIA)
- □ Sickle cell disease
- □ Endocarditis
- □ Diabetes Mellitus
- □ Thyroid Disease
- □ Crohn's Disease
- □ Vitamin A Deficiency
- □ Myasthenia Gravis
- □ Marfan's Syndrome

DRUG TOXICITY (select all that apply)

- □ Plaquenil
- □ Flomax
- □ Synthroid
- □ Acne Medication
- □ Corticosteroids
- □ Amiodarone
- □ Imitrex
- □ Anti-coagulants
- □ Digoxin
- □ EthambutoL
- □ Phenothiazine
- □ Allopurinol